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Perspective

Occupational Resilience (Part 2): Toward a Cross-culturally Relevant Measure of a Novel Construct

Bernard Austin Kigunda Muriithi[1,2] PhD, OTR/L. Milan Bimali[2] PhD

Affiliations:
[1]University of Arkansas Fayetteville, Fayetteville, AR, USA

[2]University of Arkansas for Medical Sciences, Little Rock, AR, USA

Corresponding Author:
Dr Bernard Austin Kigunda Muriithi
muriithi@uark.edu

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ABSTRACT

Occupational resilience (OR) refers to an individual's ability to persist in performing an occupation, with the duration and intensity of engagement determining resilience for each occupation. It is a key determinant of both the manner and the extent to which occupations influence health; therefore, it is a promising construct with several potential applications. There are currently no validated OR measures; which problematizes its application. Three considerations were made in designing the Occupational Resilience Measure (ORM 1.0) and evaluating its potential as a cross-culturally relevant measure of OR: 1) the findings of a published study of lived experiences of refugees from non-Western cultures; 2) Western occupational therapy theories, and 3) evaluations of six American occupational therapy scholar-clinicians. The qualitative study identified five factors that produced sustained participation in one occupation [music]. Four of these factors were developed as subscales of ORM 1.0, namely, History, Experience, Benefits, and Adaptation. On evaluating links between these factors and Western theories, we found constructs that closely align with the four factors, which are measurable and/or modifiable variables associated with long-term occupational performance. Lastly, we considered the results of six American scholar-clinicians who evaluated ORM 1.0 via an anonymous survey and supported the tool as valid, clinically relevant, and unique. The high degree of correspondence between the four ORM 1.0 factors and Western constructs suggests strong cross-cultural relevance. We recommend further studies and cross-cultural application and testing of ORM 1.0 in clinical practice and research.

Key Words: occupational resilience, occupational adaptation, occupational identity, habituation, addiction, activity persistence

INTRODUCTION

As occupational therapy is practiced worldwide, it becomes increasingly necessary to develop more cross-culturally informed tools for evaluating clients. Many existing occupational therapy assessments are designed in the West, to measure constructs defined by Western theorists and practitioners. Yet these are applied to populations that may not share Western perspectives on occupation and performance. This paper discusses one approach to develop a measurement tool while enhancing cross-cultural relevance. This approach was used in developing the Occupational Resilience Measure (ORM 1.0), which assesses occupational resilience as defined herein.

ORM 1.0 was created to measure occupational resilience (OR), which is defined as an individual's ability to persist in performing an occupation, with the duration and intensity of engagement determining resilience for each occupation (Muriithi & Gupta, 2025). Occupational resilience is strongest when an individual overcomes major barriers to pursue an occupation in spite of them. OR will be most beneficial if it includes a measurement instrument for use in clinical practice and research. The definition of OR applied in this article differs from definitions related to work (Petri-Romão et al., 2025), those that portray OR only from a positive perspective (Brown, 2021; Jacobs-Nzuzi Khuabi et al., 2022) and from activity persistence (Rosenberg, 2022). Both healthy and unhealthy occupations are included in the definition of occupation; therefore, high OR does not always signify better health (Muriithi & Muriithi, 2020).

To assess cross-cultural relevance and potentially make improvements in ORM 1.0, our process involved three considerations: a) findings from a naturalistic study involving non-Western actors [which identified five factors that engender persistence] (Muriithi & Muriithi, 2025), b) discernible parallels between the five factors and constructs from three Western theories [Model of Human Occupation (Kielhofner, 2008), Canadian Model of Occupational Performance and Engagement (Townsend & Polatajko, 2007), and Occupational Adaptation model (Schkade & Schultz, 1992)], and c) survey results from American occupational therapy scholar-clinicians. In this article we describe this process and the structure and possible uses of the new measure.

Lived experiences of refugee musicians

The use of qualitative studies to guide instrument development has been endorsed by experts (Streiner et al., 2015). However, the use of narratives of lived experiences of non-Western actors in creating ORM 1.0, for possible use in the West and across the world, was intentional. We drew from the lived experiences of refugee musicians who, after displacement from their homes in Africa and Asia, persisted in music performance across several countries including the United States (Muriithi, 2020; Muriithi & Muriithi, 2025). This study led to the term occupational resilience, as defined in this article. The phenomenological study explored lived experiences of refugee musicians (originally from collectivist African and Asian cultures) and revealed that five factors contributed to persistence in music performance [occupation] across countries.

These factors were 1) **History** (long-term participation in the activity leading to identity as musicians); 2) **Benefits** (desirable effects of the activity); 3) **Experience** (competence, talent, leading to social recognition); 4) **Adaptation** (changing to deal with environmental barriers); and 5) **Environment**

(opportunities provided by local environment) (Muriithi & Muriithi, 2023, 2025). After excluding the Environment, the remaining four factors were developed as subscales in the new measure described later below. The twenty items in the final self-report ORM 1.0 closely reflected elements that emerged from the study which contributed to enduring music performance.

Design and structure of ORM 1.0

ORM 1.0 uses a Likert-type scale which is often used in measuring related constructs (e.g., Occupational Self-Assessment (Kielhofner et al., 2009) and Canadian Occupational Performance Measure (Larsen & Law, 2025). ORM 1.0 was designed to follow familiar administration, scoring, and interpretation procedures with which occupational therapists are familiar. The scale is straightforward and suitable for self-administration; however, relevant activities must be carefully identified, if necessary, with a clinician guiding the process.

The number of items in ORM 1.0 are History=5, Experience=5, Benefits=6, and Adaptation=4. All items used the same Likert-type scale [Strongly Disagree = 1; Disagree = 2; Neutral = 3; Agree = 4 & Strongly Agree = 5]. Consequently, although the total ORM 1.0 scores range from 20 to 100, the maximum scores for individual subscales differ. These items are designed to measure the variable as understood by the refugee musicians (Muriithi & Muriithi, 2025). Utilizing scaled scores is recommended to assess the relative impact of each subscale.

The approach used to design ORM 1.0 is informed by facet theory, which posits that constructs, similar to OR, are most effectively assessed through a formative amalgamation of scores derived from multiple dimensions (Guttman, 1971; Guttman & Greenbaum, 1998). In theory, OR should be modifiable by addressing one or more of the four factors, but this is currently a hypothesis that requires empirical testing.

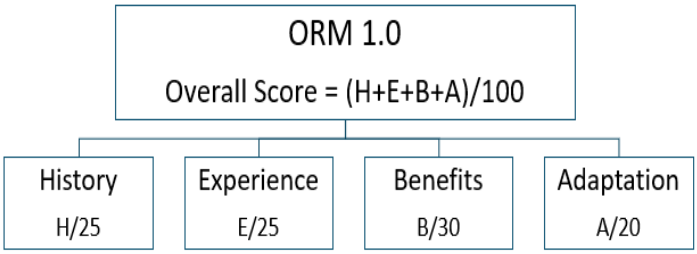

Figure 1: Structure and Domains of ORM 1.0

The formula for calculating the overall ORM 1.0 score is:

$$\text{ORM 1.0} = \frac{H}{25} + \frac{E}{25} + \frac{B}{30} + \frac{A}{20}$$

where H = History score, E= Experience score, B= Benefits score, and A =Adaptation score.

Necessity of cautious interpretation of ORM 1.0 scores

ORM 1.0 scores must be interpreted cautiously. The link between OR and health is not always linear, requiring nuanced interpretation of results based on context and actual score values. Occupations typically linked to positive health cannot always be expected to yield positive health outcomes; they could in fact lead to negative health if removed from their proper context and timing. For instance, sexual activity is viewed as a healthy human occupation without which humans would not exist, but teen pregnancy is a significant public health issue across nations (Dutton et al., 2024). Similarly, work is usually linked to positive health, but it also can produce burnout and associated health problems (Atroszko et al., 2020; World Health Organization, 2019).

The same principle applies with occupations associated with negative health. For example, consuming alcohol is known to create addiction, damage the liver, and impair health and wellbeing, but it may not pose significant health risks when undertaken infrequently or when alcohol is consumed in small quantities (Roy & Laha, 2017). This underscores the importance of considering both the intensity and duration (Muriithi & Gupta, 2025), as these—far more than mere classification of the activity itself as healthy or unhealthy—play a significant role in determining the impact of an occupation on health. ORM 1.0 scores can help discern the likely effects of an occupation on health, as the overall score reflects both the intensity and duration of engagement.

Through its ability to quantify OR across healthy and unhealthy activities, ORM 1.0 has potential to illuminate, in a new and measurable way, the nonlinear, intricate, complex, and dynamic ties between human occupation and health. Applying a single measure to all occupations acknowledges that they all belong to the same family of phenomena – things people do and consider personally meaningful. But this calls for a broader perspective on the definition of occupation. In this regard, the construct 'dark side of occupation', which is gaining traction in occupational science (Twinley, 2021), is valuable. Humans engage in healthy and unhealthy occupations; therefore, understanding participation in occupations that contribute to negative health requires shedding our human tendency to judge others. This can allow for better study and improved understanding of all activities people engage in, including those that are illegal, addictive, taboo, or unhealthy (Twinley, 2013, 2021; Twinley & Addidle, 2012).

Western Theories

It is recommended to consider theory in instrument development (Streiner et al., 2015). Doing this helped evaluate the degree to which ORM 1.0 is cross-culturally relevant. We examined several Western theories with constructs that have known or probable associations with long-term activity performance. In examining these theories, we sought to determine the extent to which the four factors that contributed to creating ORM 1.0 corresponded with measurable, modifiable variables associated with occupational performance or persistence in occupational therapy. The links between these four factors and constructs in Western theories (see Table 1) increased confidence that they could be considered cross-culturally relevant, measurable, and modifiable variables. Constructs in recognized Western occupational therapy theories, which to a reasonable extent parallel History, Experience, Benefits, and Adaptation factors, are indicated in Table 1. For example, *Habituation* and *occupational identity* closely reflect the History factor. Similarly, the Experience factor closely aligns with *occupational competence* (Kielhofner, 2008), *relative mastery* (Schkade & Schultz, 1992; Schultz & Schkade, 1992), and *occupational performance and occupational participation* (Townsend & Polatajko, 2007). Benefits and Adaptation also parallel Western theories. The strong alignment between all four factors and constructs viewed as measurable and modifiable in the West increases our confidence that a measure based on these factors would predict occupational persistence and be applicable across culture. Table 1 on the following page presents the ORM 1.0 domains and their associated constructs.

Table 1: ORM 1.0 Domains and related constructs

Muriithi & Muriithi (2025) Variables (4 ORM 1.0 domains)	**Related constructs and example of associated theory**
History – This variable considers how long one has been engaging in an activity, and how that experience has shaped identity (e.g., soccer player, musician, artist, farmer). **Principle 1: The more strongly a person identifies with an activity, due to long-term performance, the more persistent the activity becomes.**	***Habituation*** (MOHO) – "an internalized readiness to exhibit consistent patterns of behaviour guided by habits and roles and fitted to the characteristics of routine temporal, physical, and social environment"(Kielhofner, 2008), p. 52 **Occupational Identity** [as outcome of engagement] (MOHO) – "a composite sense of who one is and wishes to become as an occupational being"(Kielhofner, 2008), p. 106
Experience – This variable considers the status of activity performance, considering competence, social recognition, and attitude. **Principle 2: The more competent, socially recognized, and enthusiastic a person is in doing an activity, the more persistent the activity becomes.**	**Relative Mastery** (OA) – "the extent to which the person experiences the occupational response as efficient, effective, and satisfying to self and society" (Schkade & Schultz, 1992) p. 835 **Occupational Performance** (CMOP-E) – "the ability to choose, organize, and satisfactorily perform meaningful occupations that are culturally defined and age appropriate for looking after oneself, enjoying life, and contributing to society and the economic fabric of a community" (Townsend & Polatajko, 2007), p. 371 **Occupational Competence** (MOHO) – "degree to which one sustains a pattern of occupational participation that reflects one's occupational identity" (Kielhofner, 2008), p.107
Benefits – This variable considers the value, meaning, or benefit ascribed to an activity by an individual, but a high value does not necessarily correspond with positive health effects. **Principle 3: The greater the value (or meaningfulness) a person attributes to an activity, the greater the persistence in that activity.**	**Volition** (MOHO) – "what one holds important (values), perceives as personal capacity and effectiveness (personal causation), and finds enjoyable (interested)"(Kielhofner, 2008), p. 34 **Desire for Mastery** [assumed present] (OA) – "the person desires to produce a response to the occupational challenge that will be adaptive and therefore will lead to mastery" (Schkade & Schultz, 1992), p. 33
Adaptation – This variable concerns an individual's willingness and ability to change in response to environmental factors. **Principle 4: The greater the person's willingness and ability to change, the more persistent an activity becomes**.	***Occupational Adaptation*** (OA) – [process] "the process through which the person and the occupational environment interact when the person is faced with an occupational challenge calling for an occupational response" (Schkade & Schultz, 1992), p. 830 ***Occupational Adaptation*** (MOHO) [outcome of performance] – "the construction of a positive occupational identity and achievement of competence over time" (Kielhofner, 2008), p.107

Evaluations from Scholar-Clinicians

Consulting experts in the field during the development and validation of assessment tools is recommended and should utilize professionals with expertise in the specific area of interest (De Vet et al., 2018). After gaining approval from the Institutional Review Board (IRB) of A.T. Still University of Health Sciences (Exempt Protocol #2021-191), we invited 10 scholar-clinicians in the United States to evaluate the proposed measure for face validity, construct validity and clinical utility. We received six completed surveys.

Table 2: Survey Questions

For each statement below please select the response you agree with by circling 1, 2, 3, 4 or 5						
Absolutely Disagree (1), Disagree (2), Somewhat Agree (3), Agree (4), Absolutely Agree (5).						
1	ORM measures "an individual's degree of persistence in the performance of a specified occupation over extended periods of the individual's lifetime" [**Construct Validity**]	1	2	3	4	5
2	ORM has a high level of uniqueness compared to other behavioural and mental health assessments [**Uniqueness**]	1	2	3	4	5
3	I see the benefit of administering this kind of assessment in clinical practice. [**Clinical Utility**]	1	2	3	4	5
4	Questions in the History section are relevant in measuring OR. [**History - Content**]	1	2	3	4	5
5	Questions in the Experience section are relevant in measuring OR. [**Experience - Content**]	1	2	3	4	5
6	Questions in Benefits section are relevant in measuring OR. [**Benefits - Content**]	1	2	3	4	5
7	Questions in the Adaptation section are relevant in measuring OR. [**Adaptation - Content**]	1	2	3	4	5
8	Overall content is consistent with the construct being assessed [**Face Validity**]	1	2	3	4	5

Participants were occupational therapy clinicians with at least 10 years of assessment experience in clinical practice, who also taught in masters or doctoral programs at academic institutes in USA. All had either a Ph.D. or OTD final degree. A package was disseminated to participants via email. It comprised a copy of the assessment, justification for the new assessment, and guidelines for administration, scoring, and interpretation of results. Instructions to administer the assessment prior to completing an online survey were also included. The Qualtrics platform was used to administer the anonymous survey, asking participants to answer the questions listed in Table 2.

Data from this survey were analysed using descriptive statistics, summarized as frequency (percentage) for each of the eight questions in the survey and presented using a stacked bar diagram. The survey response rate was 60%, with six of 10 invited participants completing an anonymous survey via the Qualtrics platform. The distribution of agreement categories across each of the survey questions is presented in Figure 2 on page 7.

The assessment of content and face validity (items 1 and 8 in Table 2) yielded identical ratings: Absolutely Agree (66.67%), Agree (16.67%), and Somewhat Agree (16.67%). Regarding uniqueness (item 2 in Table 1), ORM 1.0 was perceived as unique, with ratings of Absolutely Agree (50%) and Agree (50%). Participants also viewed the administration of ORM 1.0 in clinical practice as beneficial, reflected in the Clinical Utility ratings: Absolutely Agree (50%), Agree (33.33%), and Somewhat Agree (16.67%). Participants evaluated items 4–7 (Table 1) to judge how well each item aligned with the intended construct. As shown in Figure 2, participants considered items within each subscale relevant to the construct, although the Experience subscale received slightly higher ratings (Absolutely Agree (66.67%) and Agree (33.33%)) compared with the other three subscales, which were rated Absolutely Agree (66.67%), Agree (16.67%), and Somewhat Agree (16.67%).

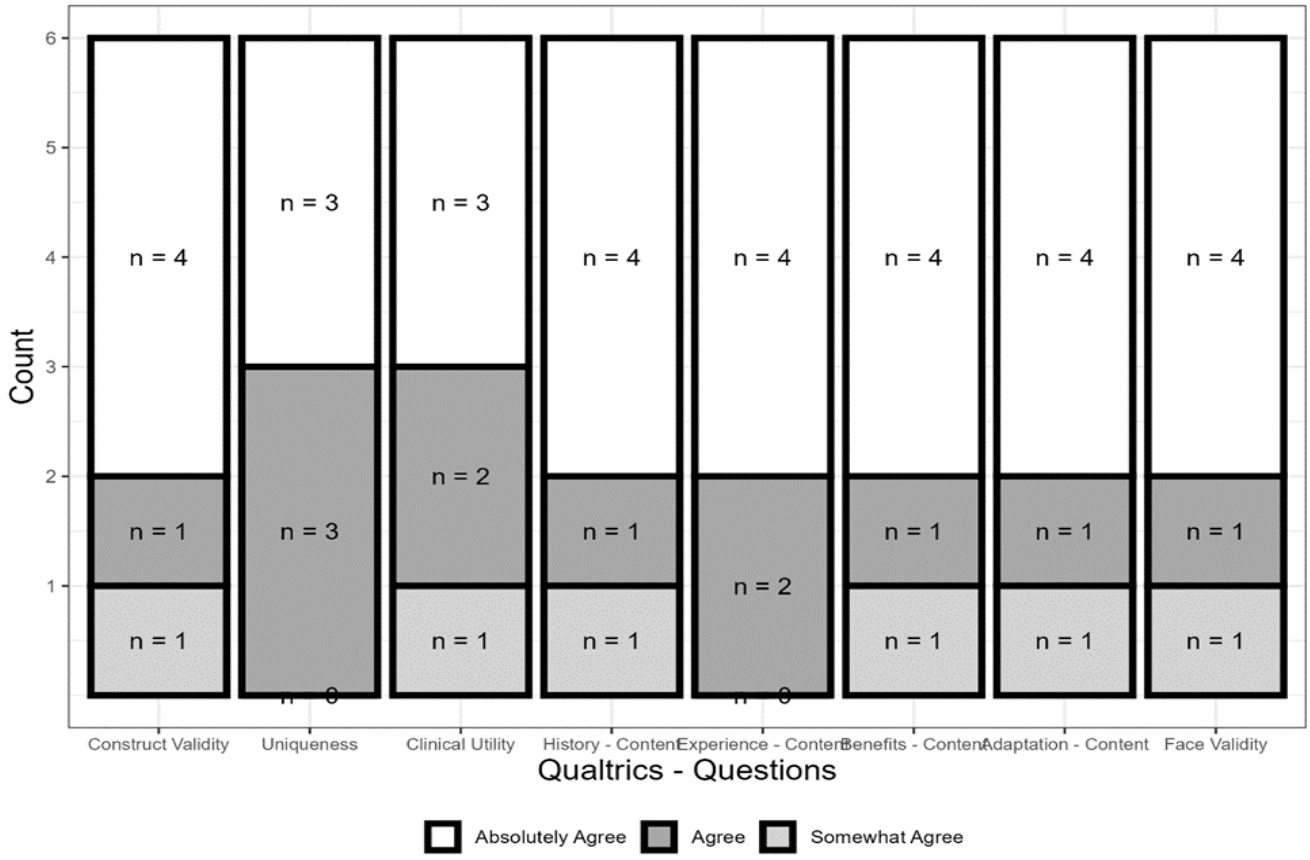

Figure 2: Survey Results

Evaluating Cross-cultural Relevance

One could evaluate cross-cultural relevance for the ORM 1.0, or other measures, by considering parallels between the variables that it measures and corresponding variables often measured elsewhere. Cross-cultural relevance can also be evaluated by consulting experts during instrument development to support the instrument design. Indeed, future developments of ORM 1.0 will involve consulting other experts and integrating feedback from varied contexts.

This process, as indicated in Figure 3, was meaningful in revealing that ORM 1.0 may be a cross-culturally relevant measure. Such an undertaking in instrument development can help identify tools that are more cross-culturally appropriate, so that clinicians are better informed when selecting tools for their populations and specific contexts. The process can also be used to improve the tools, making them progressively better when applied across cultures.

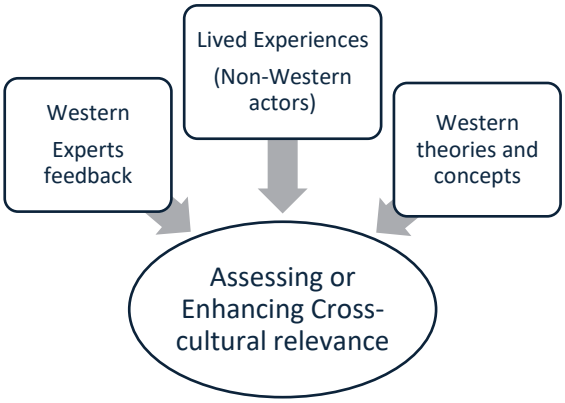

Figure 3: Evaluating ORM 1.0's cross-cultural relevance

How to Apply ORM 1.0

Clinical practice

ORM 1.0's multidimensional nature is helpful in clinical decision making. Providing subscale scores enables clinicians to identify the specific domain(s) in which a client has strengths or weaknesses, thereby facilitating more targeted interventions. A client who obtains low scores in the History subscale, for instance, indicates limited or inconsistent patterns in activity participation. For such clients, interventions that build habits and routines can foster sustained participation to improve History scores. One example of an intervention that is known to address deficits in the History domain is Lifestyle Redesign (Pyatak et al., 2022). Such interventions cultivate healthy habits and routines that, in theory, are expected to enhance occupational identity and sustain engagement.

Low scores in the Experience subscale signify that a client has limited experience or restricted performance skills. In the referenced occupational therapy theories, associated constructs are measurable and/or modifiable: occupational performance (Townsend & Polatajko, 2007), relative mastery (Schkade & Schultz, 1992) and occupational competence (Kielhofner, 2008). When skills are severely limited due to illness, developmental challenges, or inexperience, building performance skills can become the key area of focus in intervention planning.

One obtains low scores in the Benefits subscale when they lack motivation, struggle to find meaning, or express low interest in a specified activity. This factor closely aligns with volition in the Model of Human Occupation, a measurable and modifiable variable. In the Occupational Adaptation theory, the desire for mastery closely aligns with the Benefit factors, but is assumed to be present rather than a variable to be modified during practice. Some evidence-based interventions that could address a lack of motivation include motivational interviewing (Miller & Rollnick, 2023) and cognitive behavioural therapy (Beck, 2021) among others.

Lastly, a lack of creativity and problem-solving is reflected in low scores in the Adaptation subscale. Numerous assessments are available to evaluate cognitive functions associated with adaptation. Rehabilitation specialists have applied both cognitive rehabilitation [to improve cognition] and cognitive adaptation [to adapt the environment or task]. Occupational therapists already address cognitive deficits in clinical practice using well-known theory-driven approaches. Such interventions would likely result in better scores on the Adaptation subscale because they build the problem-solving skills needed for everyday occupational participation.

For occupations associated with negative health, lowering OR scores would be the goal of therapy. For occupations associated with positive health, extremely high scores may be unhealthy if they reflect a lack of balance in the occupations of a person. A clinician can help improve balance by supporting a more balanced engagement in essential occupations. Many occupations are neither classified as healthy or unhealthy, therefore, the effect of an occupation, and the kind of intervention necessary, requires nuanced interpretation of ORM 1.0 results.

Research

After studies to test sensitivity to change are done, ORM 1.0 scores can be used to evaluate the efficacy of interventions that address the referenced four factors to optimize activity performance. The overall score ranges from 20 to 100; therefore, there is

high potential for the instrument to detect changes that may occur after an intervention. A separate study showed that ORM 1.0 has test-retest reliability and internal consistency (Muriithi & Gore, 2023). Significant changes in ORM 1.0 scores may be a good indicator that an intervention changed OR, enhancing one's ability to persist in the target occupation. ORM 1.0, therefore, may be helpful in clinical trials and experiments.

Large-scale epidemiological studies may reveal the range of scores that indicate when the degree of occupational persistence is detrimental to health. This can inform public policy and guide intervention measures targeting specified populations. For example, OR scores may reveal the range of scores in work occupations that pose high risk of burnout, becoming detrimental to health. This could help identify people who are at risk of developing serious health problems, based on their OR scores for specified occupations, allowing for preventive measures to be implemented.

CONCLUSION

ORM 1.0 is a twenty-item self-report measure of occupational resilience. This article describes initial steps taken to develop and evaluate its utility and cross-cultural relevance. We recommend further studies to strengthen ORM 1.0 as a valid, reliable, cross-culturally relevant measure. We also need studies that evaluate how sensitive ORM 1.0 is to change after intervention. Researchers are invited to conduct further testing, including cautious translations and validation studies across different cultures and contexts. Potential applications of the new measure include clinical practice, clinical trials, and epidemiological research.

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