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Occupational adaptation of occupational therapists in a global crisis: Lessons learned from a Q-methodology study

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ABSTRACT

Background: The COVID-19 pandemic demanded that people adapt to meet occupational and environmental challenges. Occupational therapists facing occupational disruption had to adapt to maintain engagement in personal and professional roles. These adaptations highlight occupational science concepts, thus contributing to the epistemology of humans as occupational beings. **Aim:** A Q-methodology study explored the adaptive responses of South African occupational therapists during early COVID-19 lockdown regulations. **Materials and methods:** Seventy-eight occupational therapists participated in the study. Data were collected using Q-sorts, where participants ranked 53 statements relating to occupational adaptations. Factor analysis was performed using a Q-methodology platform. **Results:** Participants' views loaded onto three viewpoints, namely, occupational adaptation, occupational disengagement, and occupational exhaustion. Sixteen participants did not load onto any of the three themes. Most participants felt they could make a difference whilst others missed interacting with service users. A third group experienced feeling burnt out and numb. The Q-factor analysis explained 30% of the variance representing occupational therapists' views on occupational adaptation during the pandemic and their ability to engage in occupations. **Significance:** How occupational therapists applied occupational adaptation to face the challenges during and after the pandemic created tangible lessons for future pandemics or crises such as applying occupational therapy intervention principles to themselves and developing preventative and promotive programmes to influence policy on future pandemic responses. The findings expand the interpretation of occupational science concepts, with contributions to occupational adaptation, occupational disengagement, and liminality. The novel term that emerged from this research, occupational exhaustion, should be further researched.

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The extensive disruptions caused by the worldwide COVID-19 pandemic led to significant impacts on people's occupational performance, requiring them to employ diverse adaptive responses to address challenges in their work and other occupations. This disruption to daily life affected both personal and work settings, placing a demand on therapists to skilfully

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navigate the situation, to preserve or ultimately regain their roles as occupational therapists.

Healthcare professionals, including occupational therapists, were at the forefront of the pandemic and continued with service delivery under restrictive regulations and in highly infectious environments. In South Africa, occupational therapists hurriedly adapted to the different levels, continuously exploring and implementing new ways of engaging with their clients to ensure client-centred practice. A portion of occupational therapists found themselves working within COVID-19 testing units and addressing other priorities linked to the pandemic, rather than providing their typical occupational therapy services. Therapists operating in private practices, non-governmental and non-profit organisations (NGOs and NPOs), and those based in schools were prohibited from delivering their services when Level 5 restrictions were in place. However, they were permitted to resume their services once the restrictions were eased to Level 4.

During the first COVID-19 wave, the World Federation of Occupational Therapists (WFOT) issued a statement indicating that occupational therapists recognised the impact of the pandemic on the performance of occupations (Pattison, 2020). Occupational therapists and other rehabilitation professionals continued with non-COVID-19 services for people with disabilities and/or chronic conditions (Hoel et al., 2021). Rehabilitation was not seen as a priority service, which resulted in enormous challenges with implementing COVID-19 regulations and advocating for the continuation of rehabilitation services (Hoel et al., 2021). Early lockdown regulations disrupted healthcare workers' ability to instantaneously adapt how they delivered services and often required morally challenging decisions (Greenberg et al., 2020; Mehta & Edwards, 2018).

Several studies have described occupational therapists' experiences of and occupational responses to the pandemic. Ganesan et al.'s (2021) participants experienced stress and anxiety when unable to deliver services to their clients but found that telerehabilitation was useful in reducing their stress levels at work. Tse et al. (2022), using a mixed method design to investigate the occupational balance of 42 occupational therapists during COVID-19, revealed that the strategies they used were based on their professional knowledge and guided them to maintain occupational balance.

In South Africa, Phalatse et al.'s (2022; n = 16) retrospective qualitative record review found occupational therapists turned to telehealth and home programmes to continue providing essential services to their clients while adhering to social distancing and safety guidelines, but felt clients experienced occupational injustice due to the poor quality of rehabilitation services, with vulnerable populations more affected. The occupational therapists themselves also experienced negative effects. Soeker's (2022) 12 participants identified lack of government support and increased workload as contributing to burnout and anxiety. Similarly, Bruce et al.'s (2022) online cross-sectional survey identified burnout in 261 inexperienced occupational therapists (between 2 and 5 years of practice) in South Africa, 60% of whom nonetheless experienced personal accomplishment alongside emotional exhaustion.

Another experience that the COVID-19 pandemic caused was liminality for individuals and societies (Banwell et al., 2023; Cook et al., 2021; Cuervo et al., 2023; Sima et al., 2017). Lockdowns, travel restrictions, new ways of living with masks and social distancing, and sudden changes such as working remotely, brought about uncertainty, disrupted the familiar patterns of living life, and gave rise to a state of liminality. Liminality describes a passage or transition between two distinct phases or states, that in-between feeling when circumstances and situations are uncertain. It is characterised by ambiguity, fluidity, and a suspension of the usual social norms, structures, and identities (Beech, 2011; Ybema et al., 2011). Other characteristics of liminality include uncertainty of what will happen; old patterns of doing were challenged and new identities were formed. The concept of liminality helps explain people's transition through uncertain times where the old structures and patterns of participation have been disrupted (Banwell et al., 2023).

Several theories and models developed by western scholars assist with explaining why and how human beings adapt (or fail to adapt) to situations such as a global pandemic or

natural disasters. The Model of Occupational Adaptation suggests that occupational adaptation is an intrinsic, regulating human process that occurs as individuals respond to environmental demands (Grajo, 2018), using "internal processes that generate, evaluate and integrate adaptive responses" (Grajo, 2017, p. 297). Adapting to occupational challenges might mean multiple adapted responses (Kielhofner, 2008; Schkade & Schultz, 2003), as occupations are selected or organised "to improve life opportunities and enhance quality of life" (Frank, 1996, p. 50).

The focus of our research was to use an occupational lens to explore how the pandemic influenced the roles and well-being of South African occupational therapy clinicians, and to describe their adaptive responses during early COVID-19 lockdown regulations. The aim was to determine patterns of adaptation that might serve as the basis for recommending strategies for future pandemics or disasters that disrupt occupational participation, and so add to the body of knowledge around occupational science.

Materials and Methods

The study followed a Q-methodology design, which was developed by Stephenson in the 1930s and is still widely used to systematically explore people's subjective viewpoints (Rieber, 2020). Garbellini et al. (2021) promoted the use of Q-methodology in occupational therapy to understand the views of clients, colleagues, and students. Q-methodology involves a systematic enquiry approach that consists of six well-defined stages (Garbellini et al., 2021; Paige & Morin, 2016; Rieber, 2020), which we implemented as follows.

In stage 1 we developed a set of opinion statements (i.e., the concourse) derived from international literature on the impact of COVID-19 on healthcare practitioners' working lives and two online focus groups with 16 South African occupational therapists that explored the impact of COVID-19 restrictions on their practice (Uys et al., 2021). Several sub-themes emerged from this study that pointed to their occupational adaptations.

In stage 2, we worked in pairs to scrutinise the 800 statements generated in the focus groups to remove duplications and select the statements that best aligned with the aim of the study, yielding 200 statements. From these, each of the six authors independently selected statements relating to occupational adaptation, resulting in 71 statements. Then four of the authors independently rated each statement for inclusion or exclusion (yes/no). Statements with at least 75% inclusion were selected. The final concourse comprised 53 statements, which were carefully checked for formulation, grammar, and punctuation. An independent person with knowledge of Q-methodology checked the statements for clarity, relevance to the research question, and duplication. We implemented all the suggested changes to produce 53 final statements.

Stage 3 comprised purposive recruitment of a research sample of occupational therapists who had practised during the COVID-19 lockdowns and were willing to participate in the online study. Occupational therapy lecturers were excluded as they were less involved in everyday clinical practice during the first and second lockdowns. Q-methodology guidelines recommend a 1:1 ratio of participants per statement (Garbellini et al., 2021). We, thus, aimed for at least 53 participants from a variety of healthcare settings, including public and private healthcare, non-governmental organisations, and education for children with special needs. We used existing databases of practicing occupational therapists held by the Occupational Therapy Department of the University of Pretoria and the Occupational Therapy Association of South Africa (OTASA) to identify therapists to approach and access their email addresses. Additionally, we used snowball sampling by encouraging participants to forward the invitation to other therapists they knew who had practised during the pandemic. Emailed invitations included information about the study and an electronic link to the online Q-sort instrument. We used the online Q-methodology platform Q-Method Software (https://qmethodsoftware.com/) for the sorting of the statements and the factor analysis of the sorts.

In stage 4 the electronic link directed participants to the statements, where they were instructed to rank statements from most agree to least agree on a grid with 53 positions, equal to the number of statements. The grid was

arranged in a normal distribution pattern (Rieber, 2020; Schick et al., 2021). Participants dragged and dropped statements onto the grid, depending on their level of agreement. Only one statement could be placed onto each position on the grid, but participants could rearrange statements until they were satisfied with the ranking and finally submitted their grid electronically. These individual grids are called 'sorts' in Q-methodology (Ho, 2017).

Stage 5 involved performing a factor analysis using the Q-methodology platform Q-Method Software (https://qmethodsoftware.com/). Firstly, a correlation matrix assessed whether individual sorts were correlated. Factor analysis aims to reduce the number of viewpoints into factors. Similar sorts, where statements are similarly ranked, load onto the same factor. The programme starts with a default of eight factors. Factors with an Eigenvalue greater than 1 are retained (Haua et al., 2022; Hensel et al., 2022). The factor loadings can be rotated until all sorts are organised into a defining viewpoint. We selected the cluster rotation option to identify the most distinct factors with the most sorts loading onto a factor (Yamamoto & Jennrich, 2013). For the sake of clarity and consistency, we adopted the term 'viewpoints' instead of 'factors' moving forward, as each viewpoint signifies a distinct perspective of the participants.

Stage 6, the final stage, consisted of interpreting the viewpoints. We contemplated the meaning of each viewpoint by examining the distinguishing statements in the factor array of a specific viewpoint. A factor array is a grid with the statements' positions as reflected by a group of participants. Distinguishing statements have p-values less than 0.05 and differentiate the specific viewpoint from another viewpoint. The factor array was constructed using the Z-scores of the statements that loaded onto the specific viewpoint and were rearranged on a grid. Each viewpoint was then described, using the distinguishing statements and the position of statements on the factor array. We also interpreted the demographic characteristics of the participants and their loading on a specific viewpoint. We used the occupational adaptation theory (Grajo, 2017, 2018; Schulz & Schade, 2003) and other occupational science related literature (Banwell, 2023; Frank, 1996; Kielhofner, 2008; Nizzero, 2017; Sima, 2017) to guide our interpretation of the viewpoints.

Ethical considerations

The study was approved by the Faculty of Health Sciences Research Ethics Committee, University of Pretoria (Reference number: 436/2020). The first page of the Q-sort instrument was an informed consent letter outlining the purpose of the research and the storage of data. Participants were assured of anonymity and the right to withdraw at any time. The participants indicated consent by clicking an agree button on the online form.

Results

Demographics of participants

One hundred and ninety-eight therapists responded to the invitation to participate and completed the demographic questionnaire. Of those, 78 (39.4%) submitted a completed sort which exceeded the targeted sample size of 53.

Most of the 78 participants were women (89%). Participants worked in a variety of settings, including private practice (n = 33); private (n = 12) and public (n = 14) hospitals; schools offering education for special needs children (n = 10); and other settings (n = 9). Twenty (20) participants had fewer than 5 years of experience, 23 participants had 6 to 10 years of experience, 11 participants had 11 to 15 years of experience, nine had 16 to 20 years of experience, and 15 had more than 21 years of experience.

We consider our sample as a fair representation of occupational therapy clinicians in South Africa, as it encapsulates most prevalent clinical practices, including those in the public sector, private sector, schools, and nongovernment or nonprofit organisations. Table 1 shows the three viewpoints with the Eigenvalues and variance explained that emerged from the factor analysis.

The Q-factor analysis showed that 62 of the 78 participants' sorts loaded onto one of three viewpoints (Table 1). Cluster rotation revealed three primary viewpoints. Sixteen participants did not load sufficiently onto any

Table 1. Summary of Q-factor analysis (n = 78) to sort South African occupational therapists' occupational adaptation during COVID-19 lockdowns.

	Factor/ Viewpoint 1	Factor/ Viewpoint 2	Factor/ Viewpoint 3
Eigenvalue	11.06	7.4	5.6
Variance explained	14.2	9.6	7.2
Number of participants per factor	30	18	14

viewpoint, revealing idiosyncratic views. These 16 participants were dropped from the analysis, which resulted in a final sample of 62 occupational therapists.

Table 2 presents the demographic profile of the loaded participants in the first four columns. The last three columns show the correlation coefficients of the participants' sort with the viewpoint. Correlation coefficients with an * show the defining sorts of each viewpoint, in other words, those participants who defined the viewpoint. Positive values indicated agreement and negative values showed disagreement with the viewpoint.

Viewpoint 1: Occupational adaptation – We can still make a difference

This viewpoint had an Eigenvalue of 11.1 and explained 14.2% of the variance. Thirty participants (48.4%) loaded onto viewpoint 1, which had seven distinguishing statements (statements with a †, Table 3). Almost 45% of the participants (43.3%) in this group fell in the 20-to-29-year age band, followed by 30% between 30 and 39 years old and 26.7% between 40 and 49 years old. Most of the participants (73.3%) worked in private healthcare, with only 26.7% working in public healthcare settings. Half of the participants (50%) had a mixed client population (indicating treating clients of various ages, illnesses, and disabilities), followed by 30% treating adults with mental illnesses or physical conditions, and 20% treating children with diverse conditions such as learning disabilities and developmental delays.

Table 3 shows the factor array or the position of the statements for viewpoint 1. This group distinctly felt that their occupational therapy knowledge and spiritual faith helped them cope with their feelings and the challenges of COVID-19. This viewpoint highlighted that occupational therapists could still make a difference in their clients' lives, despite COVID-19. Participants in viewpoint 1 strongly disagreed that providing a high level of care was difficult and disagreed with the statement that they felt a lack of purpose. Occupational therapists in this group agreed with statements that their professional knowledge helped them organise themselves at home. They could also cope with support from professional organisations such as OTASA; interaction with social media groups; and information gained from webinars.

Viewpoint 2: Occupational disengagement – Missing interaction with service users

This viewpoint had an Eigenvalue of 7.5 and explained a variance of 9.6%. Eighteen participants (29%) loaded onto this viewpoint and had five distinguishing statements (Table 4). This was the only group with participants older than 50 years (16.7%), with 44.4% of participants being between 30 and 39 years old. The clinical practice setting was diverse and included 39% in private practice or a private hospital setting, 33.3% in a public hospital setting, and 27.7% of participants chose "other" (which included a non-government organisation, two private remedial schools, a public healthcare clinic, and a long-term frail care facility). Most of the occupational therapists in this group treated adults with mental health or physical/neurological dysfunctions.

Distinguishing statements in this viewpoint were agreement that occupational therapists missed interacting with clients (+3) and that therapy objectives could not be met due to clients being afraid of contracting the virus (+1). Occupational therapists in this group did not fear spreading the virus to family members (-3) and disagreed that they lacked exercise or leisure activities (-2). They also disagreed that occupational therapy team members had their own anxiety reactions to COVID-19 (-2). Other statements, although not distinguishing, showed that this group was unable to earn an income (+4), and were worried about the socio-economic problems of their clients (+4).

Table 2. Factor loadings of the factor analysis with cluster rotation sorting the views of South African occupational therapists (n = 62) regarding their occupational adaptation during COVID-19 lockdowns.

					Factors/Viewpoints		
	Participant code	Age group and sex	Years' experience	Practice Setting	1	2	3
1	I23933	20–29 F	< 5	Priv Prac Mental Health	0.57*	0.47	0.01
2	I24179	20–29 F	6–10	Priv Prac Mix	0.40*	-0.01	-0.28
3	I24187	40–49 F	16–20	Priv Prac Mental Health	0.68*	-0.004	0.17
4	I24193	40–49 F	16–20	Priv Prac Learn Disability	0.35*	0.34	0.004
5	I24197	40–49 F	16–20	Priv Prac Sens process	0.52*	-0.10	-0.15
6	I24210	30–39 M	6–10	Public Mental Health	0.52*	0.04	-0.01
7	I24229	40–49 F	16–20	Priv Prac Mix	0.48*	-0.06	-0.10
8	I24333	30–39 F	6–10	Priv Prac Learn Disability	0.36*	0.26	-0.012
9	I24356	30–39 F	11–15	Priv Prac Learn Disability	0.31*	0.23	-0.04
10	I24492	20–29 F	< 5	Public Orthopaedic	0.45*	-0.05	-0.03
11	I24500	20–29 F	< 5	Public clinic Mix	0.33*	0.17	-0.03
12	I24502	30–39 F	6–10	Priv Prac Mix	0.49*	-0.06	-0.15
13	I24505	20–29	< 5	Mine Health centre Mix	0.62*	0.08	-0.28
14	I24517	30–39 F	6–10	Priv Prac Mental Health	0.46*	-0.10	-0.27
15	I24519	40–49 F	> 20	Priv Prac Menalt Health	0.44*	0.22	-0.03
16	I24572	30–39 F	6–10	Priv Prac Mix	0.33*	0.31	-0.10
17	I24646	20–29 F	6–10	Priv Prac Mix	0.44*	0.11	0.33
18	I24770	30–39 F	6–10	Public Sch Phys Disability	0.52*	0.05	-0.27
19	I24774	20–29 F	< 5	Priv Prac Mental Health	0.55*	-0.27	0.20
20	I24813	20–29 F	6–10	Public Mix	0.58*	0.02	-0.17
21	I24935	20–29 F	6–10	Priv Prac Mix	0.52*	0.16	0.38
22	I24959	20–29 F	6–10	Priv Prac Mental Health	0.51*	0.14	0.12
23	I24962	30–39	6–10	Priv Prac Mix	0.48*	0.09	0.44
24	I24994	40–49 F	16–20	Priv Prac Mix	0.59*	0.16	-0.27
25	I25002	40–49 F	16–20	Priv Prac Learn Disability	0.70*	0.02	-0.003
26	I25195	20–29 F	6–10	Priv Prac Learn Disability	0.47*	0.41	-0.19
27	I25241	30–39 F	6–10	Priv Prac Mix	0.77*	0.03	-0.29
28	I25368	40–49 F	> 20	Public Mental Health	0.40*	0.18	0.15
29	I25436	20–29 F	< 5	Public Mix	0.55*	-0.31	-0.31
30	I25465	20–29 F	< 5	Public Mix	0.68*	0.04	-0.24
31	I24176	30–39 F	6–10	Priv Prac Dev Delay	0.27	0.57*	0.03
32	I24189	30–39 F	11–15	Priv Prac Mental Health	0.40	-0.52*	0.07
33	I24194	> 60	> 20	NGO Mobility Imp	0.20	0.60*	0.01
34	I24199	30–39 F	16–20	Priv Prac learn Disability	-0.05	0.50*	0.13
35	I24200	50–59 F	> 20	Priv Prac Dev Delay	0.004	0.34*	-0.02
36	I24206	50–59	> 20	Priv Prac Mix	0.40	0.60*	-0.01
37	I24459	20–29 F	< 5	Public Mental Health	0.34	-0.46*	0.25
38	I24484	30–39 F	6–10	Priv Prac Mental Health	0.22	0.45*	0.07
39	I24488	20–29 F	< 5	Public Mix	-0.04	-0.60*	0.23
40	I24491	40–49 F	16–20	Priv Prac Mental Health	0.41	0.46*	-0.01
41	I24496	30–39 F	11–15	Private Frail care	0.36	-0.51*	0.30
42	I24498	30–39 F	11–15	Priv Sch Learn Disability	-0.12	0.37*	0.25
43	I24511	30–39 F	6–10	Public Sch Mix	0.02	-0.38*	0.10
44	I24788	20–29 F	< 5	Public Mix	0.37	-0.40*	-0.02
45	I24850	20–29 F	< 5	Priv Prac Phys Rehab	-0.05	-0.50*	0.38
46	I24890	30–39 F	16–20	Public Mental Health	0.21	-0.47*	0.29
47	I24907	40–49 F	> 20	Public Mental Health	0.34	0.54*	0.05
48	I24952	40–49 F	> 20	Priv Prac Phys Rehab	0.34	-0.51*	0.20
49	I24158	30–39 F	11–15	Priv Neuro Rehab	-0.36	0.23	0.44*
50	I24202	30–39 F	6–10	Priv Prac Medico-Legal	-0.03	-0.29	0.34*
51	I24224	40–49 F	> 20	Priv Prac NICU	0.21	-0.024	0.33*
52	I24225	20–29 F	< 5	Priv Prac Phys conditions	0.12	0.27	0.47*
53	I24326	40–49 F	11–15	Priv Sch Learn Disability	0.20	-0.009	0.59*
54	I24328	30–39 F	11–15	Priv Prac Phys Neuro cond	-0.03	0.31	0.50*
55	I24335	30–39 F	11–15	Public Sch Learn Disability	0.32	-0.14	0.38*
56	I24494	20–29	< 5	Priv Prac Dementia	-0.004	-0.04	0.55*
57	I24779	20–29 F	< 5	Priv Prac Mental Health	0.06	-0.45	0.74*
58	I24784	20–29 F	< 5	Priv Prac Dev Delay	0.03	-0.43	0.54*
59	I24852	20–29 M	< 5	Priv Prac Mental Health	0.04	-0.10	0.30*
60	I24946	20–29 F	< 5	NPO School	-0.38	0.10	0.43*
61	I25001	30–39 F	6–10	Priv Sch Learn Disability	0.21	0.07	0.31*
62	I25017	30–39 F	11–15	Public Sch Learn Disability	0.31	0.28	0.49*

Note: Participants 13, 23, 33, 36, and 56 chose not to reveal their sex.

Table 3. Position of statements for **Viewpoint 1 Occupational adaptation**: We can still make a difference. (n = 30).

Statement no	Position	Z-score	Full statement
45	+4	1.671	My OT knowledge helped me to practically organize routines and programs at home.
50	+4	1.604	It was tiring to continuously adapt to the frequent regulation changes.
44†	+3	1.513	My OT knowledge helped me to cope with my own feelings and challenges e.g., to have terminology to describe what I was feeling.
39†	+3	1.479	I believe my faith trumped my fears and that is how my days were conquered.
24†	+3	1.457	I find comfort in the fact that I can still make a difference in my clients' lives despite COVID-19.
48†	+1	0.642	I was faced with so many ethical dilemmas during the pandemic and I was always asking myself if the risk outweighs the benefit.
11†	0	-0.086	I had to learn to prioritize, to accept that certain things are out of my control (e.g., power outages).
9†	-2	-0.831	During the lockdown, it was a constant mind shift to stay positive and focus on small victories.
5	-3	-1.328	I was worried about social problems of unemployment, malnutrition, food security, transport issues of service users.
2†	-4	-1.838	I found it challenging to maintain a high level of care during COVID-19.
35	-4	-1.741	I have had the feeling of lack of purpose and boredom, due to the reduced numbers of service users and lack of contact.

Note: † indicates a distinguishing statement.

Viewpoint 3: Occupational exhaustion – Feeling burnt out

Participants in viewpoint 3 reported signs and symptoms of burnout, characterised by exhaustion and feelings of detachment. Therefore, we branded this theme as occupational exhaustion. The viewpoint, with an Eigenvalue of 5.6, explained 7.2% of the variance and was defined by 14 participants (22.6%). This group was dominated by the 20-to-29-year group (43%) and the 30-to-39-year age group (43%). Only two participants fell in the 40-to-49-year group (14%). Similar to the two other viewpoints, most occupational therapists worked in a private clinical setting (78.6%). Two participants worked in a public healthcare setting, with one working at a non-profit organisation. Fifty percent of the participants treated children with learning disabilities or developmental delays.

We determined nine distinguishing statements in this viewpoint (Table 5). This group agreed that they became more exhausted over time (+3) and felt numb at times (+2). The statements that they strongly disagreed with (-4) were the importance of having clear boundaries regarding emotional involvement with clients and having compassion

Table 4. Position of statements for **Viewpoint 2 Occupational disengagement**: Missing interaction with service users. (n = 18).

Statement no	Position	Z-score	Full statement
29	+4	2.364	The implications of COVID-19 meant that I was unable to earn an income for that period.
5	+4	1.552	I was worried about social problems of unemployment, malnutrition, food security, transport issues of service users.
1†	+3	1.358	I missed the interaction with the service users.
4†	+1	0.455	Occupational therapy objectives could not be reached because service users want to be discharged as soon as possible because of the fear of contracting COVID-19.
44	0	0.097	My occupational therapy knowledge helped me to cope with my own feelings and challenges e.g., to have terminology to describe what I was feeling.
30†	-2	-0.804	The occupational therapists in the team each had their own anxiety reactions to COVID-19.
43†	-2	-0.766	The lack of exercise and/or other leisure activities made it difficult for me to cope with the daily challenges as I had no place or moment to just be and let off some steam and stress.
16†	-3	-1.442	I felt anxious about spreading the virus to my family.
51	-4	-2.146	I was anxious of being responsible for bringing the virus to the hospital where I work and infecting service users with co-morbidities.
52	-4	-2.915	The invisibility of the virus made me constantly think that I was sick even though I did not have any symptoms.

Note: † indicates a distinguishing statement.

Table 5. Position of statements for **Viewpoint 3 Occupational exhaustion**: Feeling burnt out. (n = 14).

Statement no	Position	Z-score	Full statement
50	+4	2.003	It was tiring to continuously adapt to the frequent regulation changes.
19†	+3	1.513	As I became more exhausted over time, I struggled to motivate myself to complete tasks.
12†	+2	0.911	It was good to focus on what we can be grateful for during lockdown.
25†	+2	0.878	I felt numb at times.
49†	0	-0.053	It was a daunting experience to gather and grasp all the legalities and ethical considerations around using an online platform for therapy (telehealth).
22†	0	-0.237	Learning to be adaptable was positive as well as challenging.
46†	-2	-0.753	It was valuable for me personally to sit and reflect on how COVID-19 impacted my professional life.
31†	-3	-1.769	I had concerns about the availability of PPE in order to keep service users and staff safe.
34†	-3	-1.438	It has been a positive experience taking on new creative ways of doing things differently.
38	-4	-1.940	I had more compassion and empathy and felt more committed as I now better understand how the service users feel during the COVID-19 pandemic.
37†	-4	-2.047	I had to (even just in my head) have clear boundaries in terms of my emotional involvement with service users.

Note: † indicates a distinguishing statement.

and empathy with their clients. They disagreed that they were concerned about the availability of personal protective equipment to keep everyone safe and taking on new creative ways of doing things differently. These were strong indications that they experienced occupational exhaustion in that they presented with symptoms of burnout due to an increase in personal and professional demands. They had to constantly adapt to the occupations they fulfilled either by doing things differently or by losing occupations which contributed to occupational balance. They felt indifferent about the statement that learning to adapt was positive and challenging (0) and the legal and ethical aspects of the online platform for therapy (telehealth) (0). One positive statement, among the feelings of exhaustion and lack of compassion, was the agreement that it was good to focus on feelings of gratitude during lockdown (+2).

There was only one statement that showed agreement across viewpoints (no 20): "*I have feelings of guilt about keeping service users safe from contracting the virus.*" This statement had a z-score of -0.858 and a position of -2 for viewpoint 1, a z-score of -0.807 and a position of -2 for viewpoint 2 and a z-score of -0.666 with a position of -1 for viewpoint 3. Participants did not feel guilty that they may have infected clients.

There was little correlation between viewpoints. Viewpoints 1 and 2 were the least correlated (0.032), while viewpoints 2 and 3 were negatively correlated (-0.072), and viewpoints 1 and 3 were most correlated (0.086). Finally, Figure 1 shows the factor array of viewpoint 1 with the most popular views.

Discussion

In this study, we used Q-methodology to explore the views of how South African occupational therapists adapted to the COVID-19 lockdowns. Three viewpoints emerged from the factor analysis. The strongest view maintained by occupational therapists was that they felt they were still able to provide high quality care to clients despite the challenges of COVID-19 lockdowns, thus successfully adapting to the disruptions caused by the global pandemic. They did not view telehealth as a barrier, but rather as an enabler of care, similar to the Hong Kong occupational therapists (Ganesan et al., 2021). The second viewpoint encompassed the sentiment that occupational therapists missed interacting with their clients, whilst the third viewpoint represented a group of occupational therapists who experienced occupational exhaustion across various occupations. These three viewpoints only explained 30% of the variance in the Q-sorts, suggesting that there were participants with idiosyncratic views who did not correlate with any of the viewpoints.

During the factor analysis, we explored the Q-sorts using cluster rotation to see if more viewpoints emerged. The three-factor model had the most sorts loading to one of the three viewpoints. Ideally, factor analysis should account for most of the variance in Q-methodology, but we

-4	-3	-2	-1	0	1	2	3	4
2. I found it challenging to maintain a high level of care during COVID-19.	4. OT objectives could not be reached because service users want to be discharged as soon as possible …	6. I became quite anxious … but once I had a plan, I felt more in control.	1. I missed the interaction with the service users.	10. I tried to focus on one day at a time… thinking ahead caused too much uncertainty and anxiety.	21. I had to juggle a lot of new roles and tasks at home and/or work.	26. I have adjusted to the new normal and feel more in control in providing therapy…	24. I find comfort in the fact that I can still make a difference in my clients' lives despite COVID-19.	45. My OT knowledge helped me … organise routines & programs at home.
35. I [felt] lack of purpose & boredom, due to the reduced … service users and lack of contact.	5. I worried about … unemployment, malnutrition, food security, transport issues of service users.	7. It really helped to 'sit myself down' and apply the tools I teach to my clients.	8. I had to pay more attention to my routine ([sleep, eat well, exercise & designated me-time].	11. I had to learn to prioritise, to accept that certain things are out of my control …	22. Learning to be adaptable was positive as well as challenging.	27. I experienced fluctuating emotions while adjusting to the initial stages of lockdown.	39. I believe my faith trumped my fears and that is how my days were conquered.	50. It was tiring to continuously adapt to the frequent regulation changes.
	15. I was in survival mode which influenced what I did in my therapy sessions.	17. Despite feeling resilient and adaptable, the shift to telehealth caused anxiety.	13. When I was well-informed about COVID-19 regulations, I could start working with more confidence.	12. It was good to focus on what we can be grateful for during lockdown.	36. I [was scared] as the risk of contracting COVID-19 was just so high.	30. The OTs in the team each had their own anxiety reactions to COVID-19.	41. I coped by … doing what I can in a day, & what was not done today, could be done next day.	
	25. I felt numb at times.	20. I [felt guilty] … keeping service users safe from the virus. (Consensus statement)	18. Keeping up with work obligations was difficult because of increased … anxiety and stress.	14. I learned that if I care for myself first, I will have greater capacity to care for service users.	38. I [felt] more compassion, empathy & [commitment] … better understand how clients feel.	34. It has been a positive experience taking on creative ways of doing things…	44. OT knowledge helped me cope with feelings & challenges (e.g., describe what I was feeling).	
	28. I had less patience with people.	31. I had concerns about the availability of PPE to keep service users and staff safe.	19. As I became more exhausted over time, I struggled to motivate myself to complete tasks.	16. I felt anxious about spreading the virus to my family.	43. Lack of exercise / leisure made it difficult for me to cope with the daily challenges ….	42. Debriefing & speaking openly about our fears … made it easier to deal with	53. Professional organisations / social media supplied inspiring … information & webinars …	
		3. Social distancing negatively impacted the cohesion needed [for] group therapy.	29. The implications of COVID-19 meant that I was unable to earn an income for that period.	23. I find the provision of therapy under COVID-19 physically and mentally draining.	47. I have experienced compassion fatigue.	46. It was valuable … to sit & reflect on how COVID-19 impacted professional life.		
		9. … it was a constant mind shift to stay positive and focus on small victories.	32. Staff were quite timid and quiet during the first weeks back at work but slowly [found] their voices…	33. While adapting & getting used to the regulations / restrictions, part of me stayed in survival mode.	48. I was faced with so many ethical dilemmas … always asking if the risk outweighs the benefit.	51. I was anxious about … infecting service users with co-morbidities.		
			37. I had to … have clear boundaries in terms of emotional involvement with service users.	40. It was difficult to know which information / news to trust … caused uncertainty & anxiety.	49. It was daunting to … grasp all legalities & ethical considerations around using telehealth.			
				52. The invisibility of the virus made me … think I was sick [despite not] having symptoms.				

Note: Shaded cells define this factor and are statistically significant. OT = occupational therapy. OTs = occupational therapists. Some statements have been abbreviated to fit.

Figure 1. Factor array (position of statements) of viewpoint 1.

must recognise the implications of the unexplained variance. We acknowledge that occupational therapists likely had diverse views on their occupational adaptation during the COVID-19 lockdowns, suggesting that our chosen statements captured varying discourses. Amongst the three viewpoints, we recorded agreement on only one statement, "*I have feelings of guilt about keeping service users safe from the virus*", further supporting the idea that occupational therapy clinicians adapted diversely.

We also noted that viewpoints were weakly correlated and that there was little overlap between viewpoints, further suggesting that occupational therapists experienced the impact of COVID-19 in vastly different ways. We noted opposing statements in factors, for example, "*I was worried about social problems of unemployment, malnutrition, food security, transport issues of service users*". Participants in viewpoint 1 disagreed (-3) with this statement, while participants in viewpoint 2 strongly agreed (+4). The different opinions may be explained by different demographic characteristics, with viewpoint 1 participants working mainly in private practice, where they may not have been confronted with the social challenges in public settings. Contrastingly, these challenges were keenly observed by viewpoint 2 participants in public hospital settings.

Viewpoint 1: Occupational adaptation

Within viewpoint 1, the participants demonstrated high levels of occupational resilience (Brown, 2021). Occupational resilience includes a person's ability to adapt to changing demands in the environment, which Gabrys et al. (2018) referred to as cognitive flexibility, which gives a person a sense of power. This viewpoint was supported by the distinguishing statements, "*I find comfort in the fact that I can still make a difference in my clients' lives despite COVID-19*" (+3); "*I believe my faith trumped my fears and that is how my days were conquered*" (+3). These distinguishing statements were reinforced by a statement which the participants strongly disagreed with, namely "*I have had the feeling of lack of purpose and boredom, due to reduced numbers of service users and lack of contact*", thus showing resilience.

Participants in viewpoint 1 also agreed with the statements, "*My occupational therapy knowledge helped me to cope*" and *"Occupational therapy knowledge helped me to practically organise routines and programmes",* which may explain why they felt empowered. These occupational therapists felt that their professional training gave them the knowledge to cope with their feelings and challenges, to organise themselves and follow a routine ("*My OT knowledge helped me to practically organise routines and programs at home*"). Participants in this group had occupational resilience, namely the ability to apply changes and modify their daily occupations (Gabrys et al., 2018). This finding is similar to an Australian study (Tse et al., 2022), where occupational therapists experienced occupational balance during COVID-19 restrictions because they applied their own theoretical approach to adaptation.

The participants managed to modify their daily occupations in several ways. They continued to use available resources, such as "*Professional organisations and/or social media inspiring support in terms of information and webinars during lockdown*". While it is difficult to determine if participants in viewpoint 1 had an inherent ability to cope or take initiative, our findings show that they demonstrated useful skills for dealing with uncertain times ("*I have adjusted to the new normal and feel more in control in providing therapy to service users*"); and found creative solutions to new problems ("*It has been a positive experience taking on new creative ways of doing things differently*"). People who are creative are often flexible and more capable of occupational resilience (Brown, 2021). Participants in viewpoint 1 strongly disagreed that they "*found it challenging to maintain a high level of care during COVID-19*". Although "*it was tiring to continuously adapt to the frequent regulation changes*", these participants did not show signs of burnout and were willing to take on new creative ways of doing things, pointing to successful occupational adaptation.

Viewpoint 2: Occupational disengagement

Participants in viewpoint 2 shared the commonality of not "*feeling anxious about spreading the*

virus to their families" (-3) and "*I missed the interaction with the service users*" (+3). Participants wanted to continue delivering therapy, but only emergency services were allowed during the hard lockdown (Level 5 restrictions). Isolation negatively impacts occupational engagement, which, according to Brown (2021), can lead to mental health problems. In our study, most of the participants were female, who had the greatest risk of developing depression after experiencing traumatic events such as a hard lockdown (Lasalvia et al., 2021).

Healthcare workers may also experience moral injury if they cannot provide the high quality of care they promised to clients, even when working in a close-knit multidisciplinary team. Moral injury can be experienced by individuals who feel a profound sense of guilt, shame, or moral conflict as a result of their actions, or the actions of others, that contradict their personal values, ethical principles, or societal norms (Jinkerson, 2016). Čartolovni et al. (2021) and Grobler (2020) have explained that moral injury may cause healthcare workers to be frustrated and experience emotional turmoil when having to make decisions that cause health injustices and even suffering. Occupational therapists in viewpoint 2 likely experienced moral injury in relation to the early discharge of their service users and they could not reach treatment objectives ("*Occupational therapy objectives could not be reached because service users want to be discharged as soon as possible because of the fear of contracting COVID-19*"). The fact that they strongly agreed that they were "*worried about social problems of unemployment, malnutrition, food security, (and) transport issues of service users*" (+4), showed that they could experience emotional turmoil as their hands were tied and they could not provide occupational therapy services. Therapists working in public hospitals and other settings, such as non- government organisations (NGOs), supported this statement (Table 2).

Therapists working in public hospitals largely continued to receive an income throughout the COVID-19 lockdown, whilst many therapists working in NGOs lost their incomes ("*The implications of COVID-19 meant that I was unable to earn an income for that period*"). Working in public hospitals with level 5 restrictions, or losing an income in private practice, may have fostered empathy with service users who were in the same situation but also generated frustration as they could not continue services.

Since the participants were disengaged from their practice or had fewer clients to service, they possibly had less clinical demand and fewer opportunities for compassion satisfaction. The participants were concerned that "*occupational therapy objectives could not be reached because service users want to be discharged as soon as possible because of the fear of contracting COVID-19*". Compassion satisfaction and compassion fatigue are two sides of the same coin (Collins & Long, 2003). Compassion satisfaction may support a carer's will to work and protect against compassion fatigue and burnout. Participants in viewpoint 2 had no or little interaction with clients ("*I missed interaction with the service users*"), with little opportunity for compassion satisfaction, and a decreasing experience of occupational engagement. The core for healthcare workers, namely compassionate care and compassion satisfaction, did not manifest and possibly resulted in occupational disengagement.

A large group of therapists were unable to fulfil their purpose through vocational occupation, which affected their well-being. Similarly, Luck et al. (2022) described that people living with chronic disease during COVID-19 lockdowns also experienced loss of occupational engagement and decreased connectedness. Participants in viewpoint 2 may not have been able to adapt, or seek new occupations, or effectively modify their existing occupations, which could have solved their feelings of disengagement (Sima et al., 2017). Occupational engagement is central to our identity, thus, when we lose our primary occupation, our identity may be affected (Nizzero et al., 2017). This can lead to a disconnection of the self (Hansson et al., 2022), which, as we could see in these participants, leads to reduced well-being.

Viewpoint 3: Occupational exhaustion

South African occupational therapists that loaded onto viewpoint 3, experienced occupational exhaustion. We used the three dimensions of burnout (World Health Organization

[WHO], 2018) to highlight the nature of occupational exhaustion in viewpoint 3.

The first dimension of burnout speaks of energy depletion and exhaustion (WHO, 2018). Participants in this group agreed with statements of becoming exhausted over time and not exerting energy on new creative ways of doing things. They strongly identified with the statement of "*It was tiring to continuously adapt to the frequent regulation changes*" (+4).

The second dimension of burnout describes mental distance from one's job (WHO, 2018). In our study, statements selected by participants included feelings of detachment and experiencing less compassion and empathy with clients. The statement that distinguished the participants in viewpoint 3 from the other two viewpoints, was the strong disagreement with: "*I had to have clear boundaries in terms of my emotional involvement with service users*" (-4). This indicated feelings of detachment. They felt indifferent about their ability to adapt ("*Learning to be adaptable was positive as well as challenging*"); and did not see the need to reflect on the impact of COVID-19 on their professional life; further supporting a state of detachment.

The third dimension of burnout relates to reduced professional efficacy (WHO, 2018). In a client-centred profession such as occupational therapy, lack of compassion and feeling numb will have a detrimental effect on professional efficacy. A lack of empathy and compassion for one's clients may represent a form of depersonalisation in the burnout syndrome (Maslach & Leiter, 2017) and can be viewed as occupational exhaustion. Occupational therapists in viewpoint 3 identified with the statement "*I feel numb at times*" and disagreed with the statement: "*I had more compassion and empathy and felt more committed as I now better understand how the service users feel during COVID-19 pandemic*". They were not concerned about the availability of PPE ("*I had concerns about the availability of PPE in order to keep service users and staff safe*").

It is concerning that therapists identified feeling numb and experienced lack of compassion and empathy. The lack of compassion satisfaction reported by participants in viewpoint 2 is also concerning, as it may be a precursor to burnout or occupational exhaustion, as labelled in this study. Tahiri et al. (2022) assessed the burnout levels of doctors and nurses with the French Maslach burnout inventory in the workplace and called it occupational exhaustion. We came to the realisation that occupational exhaustion from an occupational science point of view, is more than the general burnout concept that primarily focuses on the workplace. The WHO (2018) definition of burnout states that it is a long-term exposure to workplace stress that has not been successfully addressed and goes further to identify the three dimensions as explained above. We would like to argue that a preliminary definition of occupational exhaustion is when the demands of everyday life, and not only workplace stress, consistently exceed a person's performance capacity to engage with the demands meaningfully and productively. When a person's capacity to successfully engage in roles and their associated occupations is challenged to a point where the person feels physically and emotionally exhausted, and where they become detached from their responsibilities in the different occupational roles they fulfil and have lost the feeling of mastery in occupational participation, they are in a state of occupational exhaustion.

Occupational exhaustion relates to other occupational science concepts. For example, occupational exhaustion may be the result of occupational imbalance where excessive time is spent in one occupation at the expense of other occupations (Durocher et al., 2014). When balance between restorative and productive roles and occupations have been disrupted or skewed, the person may consistently experience role overload and lack of occupational satisfaction in these roles. The constant feelings of not coping with the demands and no sense of competence and mastery, could lead to a loss or change in occupational identity. Occupational identity is tied to onchoice and interest in occupations; as well as the skills, knowledge, and expertise that individuals acquire and develop through their engagement in occupations (Kielhofner, 2008). If meaningful engagement is challenged, the therapists' occupational identity is also challenged.

Whilst many studies have investigated burnout in healthcare workers during the COVID-19 pandemic, few have focused on occupational

therapists. In Greece, Kyriazos et al. (2021) reported that resilient occupational therapists had a lower risk of developing burnout. This study concluded that occupational therapists could learn the skill of resilience (Kyriazos et al., 2021). This concurs with the South African study who found that despite the emotional exhaustion, 60% of the participants experienced personal achievement (Bruce et al., 2022), which may indicate that novice therapists have the resilience to adapt to adverse conditions such as COVID-19.

Participants in viewpoint 3, many of whom were treating children (Table 2), may have experienced occupational disruptions to their occupational engagement during the highest lockdown levels. The lack of occupational engagement may have exceeded their capacity to adapt and hampered their ability to return to their routine, which could be a sign of liminality. In our study, participants had to deal with less occupational engagement with children through telehealth. For these therapists, the situation may have exceeded their adaptive capacity, and they could not identify with previous levels of compassion and caring. A study by Ganesan et al. (2021) in Hong Kong showed that telehealth was also mostly done with children, but occupational therapists reported that the technology counteracted their feelings of stress, social isolation, and being distanced from their clients. It seems that telehealth helped them to become 'unstuck' with their feelings of stress and social isolation.

Søvold et al. (2021) reminded healthcare workers that awareness of one's emotions and stress is an important mechanism to self-care and ensuring mental health. Many physicians are reluctant to seek mental healthcare due to stigma and fear of professional consequences (Søvold et al., 2021). It is encouraging that occupational therapists in viewpoint 3 acknowledged their struggles. They could express their emotions and were aware of non-coping behaviour. This is the first step to seeking support and receiving mental health intervention, which, in the long run, builds emotional resilience and fosters well-being (Luck et al., 2022).

Viewed from the perspective of occupational adaptation theory (Grajo, 2017, 2018; Schkade & Schultz, 2003), the participants in viewpoints 2 and 3 could have experienced degrees of occupational dysadaptation. This includes being unable to perform their occupational roles, experiencing a feeling of being overwhelmed by their role responsibilities and demands, and not being able to or having difficulty overcoming their occupational challenges (Schkade & Schultz, 2003). Occupational dysadaptation may be temporary, or the therapists may have experienced this constantly and, thus, would have required intervention to ensure that they could become 'unstuck' (Schkade & Schultz, 2003).

Participants in our study experienced severe occupational disruption in the form of liminality. Sima et al. (2017) also reported that a group of their participants could not accept the changes to their environment nor adapt to the situation. Many participants became detached from the occupations they engaged in before the disaster. Participants in viewpoint 3 were also unable to adapt to the new way of providing healthcare and felt a great loss of attachment to their work occupation. They were burnt out and felt numb, thus unable to offer effective services. We refer to this as being in a liminal stage of adaptation, being caught between reality and what they are supposed to do. People find it hard to cope with liminality and, like participants in viewpoint 2, also lose their sense of identity as occupational therapists which may lead to moral injury.

Our findings are similar to the occupational adaptation behaviours observed in people who survived a cyclone in Northern Queensland, Australia (Sima et al., 2017). This further demonstrates the gravity of the COVID-19 lockdown restrictions and their impact on occupational engagement. In our study, many healthcare workers observed the negative effect of occupational disruption on their clients' emotional and social well-being, which affected their own well-being. Like survivors in Australia (Sima et al., 2017), participants in our study used their prior knowledge about occupational adaptation to overcome occupational disruption and thrive in their own contexts. At the time of this study, not all South African occupational therapists had adapted.

We acknowledge limitations in the study. It was observed that out of the initial 189 participants, only 78 completed all the statements. The low

completion rate raises the possibility that sorting the 53 statements was a time-consuming process, potentially affecting participant engagement.

Moreover, participants who experienced occupational exhaustion may have found the Q-sort too cumbersome to complete. Future Q-methodology studies should carefully consider the occupational disruption and state of well-being of the potential participants when deciding on the number of statements that participants must sort. Striking a balance in statement volume in Q-methodology ensures a more accessible and accommodating research process, encouraging greater participant involvement and, consequently, contributing to the overall robustness of the study outcomes.

Recommendations

We advocate that in future pandemics and disasters, knowledge of occupational adaptation to be taken up by all healthcare workers. In our study and that of Tse et al. (2022), the occupational therapists who successfully transitioned through the changes were those who applied the theory. Therapists risk of experiencing occupational dysadaptation also needs to be highlighted, to spur the development of preventive and promotive programmes before any further disasters or pandemics arise. This could enable healthcare workers to increase their mastery of occupations when facing disruptions. Some research evidence indicates ways in which this might be done (de Vries et al, 2023; VanPuymbrouck & Olson, 2022).

The data collection for this research occurred during the first COVID-19 wave in South Africa. At this time, many participants expected that the pandemic would be over in a few months. Since then, we have experienced subsequent waves of the pandemic and eventually, the termination of all restrictions. A follow-up study would indicate the modes of responding to occupational disruption in dealing with the long-term effects of a pandemic or any similar crisis. Post-pandemic surveys on occupational adaptation of healthcare workers would show if these three viewpoints are still present, even after the restrictions have been lifted.

It is important to continuously monitor and address evolving needs and experiences of healthcare workers during future pandemics or times of crisis to stay informed about their successes, challenges, and concerns. Support measures and interventions could then be adjusted accordingly to ensure they remain relevant and effective in meeting healthcare workers' changing needs.

Since we are proposing a new term of occupational exhaustion, the concept should be explored further through grounded theory studies and scoping reviews. Healthcare workers should be aware of the signs and symptoms of occupational exhaustion. Proactive steps to mitigate occupational exhaustion in light of possible future pandemics and disasters, and further ways of supporting colleagues to prevent occupational exhaustion, ought to be developed. This could include creating a supportive work environment, setting clear emotional boundaries, seeking support from colleagues and supervisors, and practising self-care strategies. Therapists should also foster a sense of compassion and empathy towards clients, as these qualities contribute not only to professional efficacy and job satisfaction but also to overall well-being.

It is crucial for healthcare workers to address the emotional toll of occupational disengagement by recognising the impact of reduced client interaction. They should actively seek ways to maintain engagement with clients, even in remote or virtual settings. Additionally, therapists should be mindful of the potential moral injury experienced when unable to provide the desired level of care and be empathetic towards the social challenges faced by clients.

Support and interventions should be tailored based on demographic factors, recognising the influence of demographic factors, such as age and work setting, on healthcare workers' experiences and needs. Targeted interventions and support systems should be developed that address the specific challenges faced by different demographic groups. For example, consider the unique concerns of healthcare workers employed in private practice versus those in public hospitals or non-governmental organisations. Collaboration and knowledge sharing should be encouraged to promote a sense of community and professional growth during times of crisis. Platforms should be created to exchange experiences, facilitate the use of available resources and support

structures, and share best practices and innovative approaches to adapt to the challenges posed by future pandemics and disasters.

An occupational perspective also has potential to inform policy on future pandemics, epidemics, or disasters, to support the provision of rehabilitation services for people with disabilities and/or chronic illnesses. During the pandemic, some rehabilitation services were viewed as non-essential services. Taking an occupational perspective will inform advocates for occupational therapy services to become essential services before the next pandemic or disaster happens. People with disabilities and/or chronic illnesses must face challenges in everyday living and need support when a pandemic or natural disaster adds additional challenges. Restricted therapy services not only affect their occupational participation but also affects the compassion satisfaction of therapists, which impacts on their occupational adaptation.

Finally, education programmes for health professionals should incorporate competencies for resilience, adaptability, and self-care strategies in their curricula, to prepare future practitioners to navigate challenging situations like the COVID-19 pandemic. This can include strategies for managing personal challenges; finding comfort in their professional knowledge and personal faith; and utilising resources such as professional organisations, social media groups, and webinars for support and information. This will help foster a resilient and proactive mindset, enabling healthcare professionals to adapt and thrive in times of crisis.

Conclusion

Occupational therapists in South Africa experienced early COVID-19 lockdowns in different ways, especially in terms of occupational adaptation. Three viewpoints emerged from our analysis. The most prominent viewpoint included therapists who exhibited occupational adaptation and felt that they were still able to make a difference, despite the challenges of the COVID-19 lockdown. These therapists relied on their professional knowledge and skills to cope with the challenges of lockdowns during the pandemic. A second, but less prominent, group of therapists felt occupationally disengaged and missed interacting with clients. Opportunities to experience compassion satisfaction were lost and this affected their well-being. The third viewpoint came from participants who were burnt out with feelings of occupational exhaustion. The relevance of the findings extends beyond South Africa. COVID-19 lockdowns required occupational adaptation from many healthcare workers across the globe. Reflecting on how occupational therapists used occupational adaptation to meet the challenges faced in South Africa during and after the pandemic highlighted the positive impact of adaptive responses during a global crisis.

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