

THE OCCUPATIONAL THERAPY PRACTITIONER: COPING SKILLS DURING
THE COVID-19 PANDEMIC

A Thesis submitted to the faculty at Stanbridge University in partial fulfillment of the
requirements for the degree of Master of Science in Occupational Therapy

by

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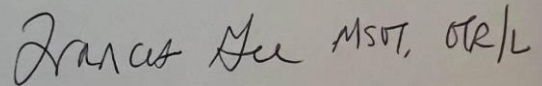
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November 2022

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Certification of Approval

I certify that I have read *The Occupational Therapy Practitioner: Coping Skills During the COVID-19 Pandemic* by Neil Kim, Dennis Lam, Maegan Mangilog, and Tommy Vu , and in my opinion, this work meets the criteria for approving a thesis submitted in partial fulfillment of the requirements for the degree of Master of Science in Occupational Therapy at Stanbridge University.



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Acknowledgements

We would like to thank our thesis advisor, Frances Gee, for her continuous support

Abstract

Background: The COVID-19 pandemic impacted the world of health care. There was a lack of research on how occupational therapy (OT) practitioners, including OTs and certified occupational therapy assistants (COTAs), coped with the difficulties of working through the pandemic.

Objective: The purpose of the study was to collect data about the coping abilities of occupational therapy professionals during the COVID-19 pandemic.

Method: The research used a mixed–method approach, including a descriptive, correlational, and phenomenological design. Participants were sampled via social media. The criteria were that participants must be OT practitioners who are currently practicing. We collected our qualitative and quantitative data through questions on a Google Form online survey using the Brief COPE inventory and two open-ended questions. The data was analyzed using the analytical software Statistical Package for the Social Sciences and Dedoose.

Results: In total, 30 OTs and COTAs were counted for data analysis. Using a T-Test, we found no significant difference between coping skills between practitioners of different backgrounds under the Brief COPE inventory. The most used coping skill was acceptance, and the least used coping skill was substance use. From the two open-ended questions, we found that the most coping skill involves socializing with others.

Conclusion: OT practitioners deal with the reality of their situation by adapting to their environment and reframing their thinking. Designing a longitudinal study with a multitude of assessments and participants can provide additional insight into the effectiveness of coping mechanisms throughout the COVID-19 pandemic.

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The Occupational Therapy Practitioner: Coping Skills During the COVID-19 Pandemic

The COVID-19 pandemic was due to a highly contagious respiratory virus that caused mild to severe flu-like symptoms and potentially resulted in death. The severity of the virus reshaped daily life for those who work in healthcare. Healthcare workers faced an influx of sick and contagious patients, increased work hours, and shift changes. As a result of these factors, healthcare workers were faced with escalating rates of stress and job burnout at a critical moment when COVID-19 was further burdening the healthcare system as a whole (Liberati et al., 2021). Occupational therapists (OTs) and certified occupational therapy assistants (COTAs) were valued healthcare workers that had to adapt and rethink their current approach to therapy services while developing a means to cope during the stress-inducing events of the pandemic.

Statement of Problem

The purpose of the study was to collect data about the coping abilities of occupational therapy practitioners during the COVID-19 pandemic. Occupational therapy was a vital profession for rehabilitating individuals whose careers and lives were affected by the COVID-19 pandemic. Between March and April 2020, a survey conducted by the American Occupational Therapy Association (AOTA) showed that OTs, COTAs, and occupational therapy students showed increased support that the occupational therapy profession was essential in nearly all healthcare settings: long-term care, skilled nursing facilities, hospitals, schools, and outpatient (AOTA, 2022). Across all settings, there was at least a 20% increase for essential occupational therapy services, with the percentage

being about twice as much in free-standing outpatient and school settings. On average, COTAs had a higher percentage of increased need.

OTs were required in every healthcare setting, and it was necessary that the profession was prepared for personal and professional crisis management during a pandemic occurrence. In past studies, healthcare workers exhibited extreme stress, were emotionally injured and traumatized, and had extreme levels of symptoms of depression and anxiety (Munawar & Choudhry, 2021). Healthcare workers also reported fears of bringing these stressor experiences home and spreading the COVID-19 virus to loved ones (Munawar & Choudhry, 2021). A higher risk of these mental health issues was seen in healthcare workers with direct patient contact. OTs were most often found in these settings where direct patient care was required for proper services to be provided. For occupational therapy services to be effective, an intervention plan may require repetitive activities, which may be difficult to administer and adhere to due to isolation or distancing protocols (Ganesan et al., 2021).

It was therefore critical to identify effective coping skills that occupational therapy practitioners can use in their personal and professional lives due to stressors because of the pandemic. The emergence of this fear-inducing and life-changing situation has resulted in various mental health issues such as post-traumatic stress disorder, panic disorder, anxiety, and depression (Munawar & Choudhry, 2021). Minimal research was published on the coping skills of occupational therapy professionals in these stressful situations. The information gathered through this investigation can close the gap in the literature and provide knowledge and recommendations about coping skills relevant to new and current occupational therapy professionals in any stressful situation.

Literature Review

Theme I: Reports of High Stress, Anxiety, and Burnout

The progression and severity of COVID-19 had a severe impact on the healthcare system, which created a huge strain on workers. According to Frenkel et al. (2022), healthcare professionals were critical in saving lives and reducing the impact of the pandemic on individuals. Frenkel et al.'s (2022) literature review found that healthcare professionals reported high stress, anxiety, and burnout due to the demanding circumstances of providing patient care in the context of the pandemic. Increased demands and responsibilities in mitigating the effect of individuals with COVID and organizations or companies unprepared readiness for a pandemic contributed to these psychological stresses. Many workers were overwhelmed by the rapid changes in services and the intense nature of the work. The COVID-19 pandemic's negative impact on the mental health of healthcare professionals follows similar patterns noted in previous disease outbreaks (Liberati et al., 2021). Depending on the available coping resources, the environmental demands placed on the individual lead to stress (Frenkel et al., 2022). The limitation of the Frenkel et al. (2022) study was that a small number of participants answered the survey. Since the number of participants was small, it cannot be reliably generalized to the entire population; nevertheless, the results were consistent with the findings in other literature.

According to both Liberati et al. (2021) and Greenberg et al. (2020), moral injury in healthcare professionals was common during the pandemic. Moral injury describes the psychological distress resulting from actions or the lack of action that violate the individual's moral or ethical beliefs (Greenberg et al., 2020). According to the healthcare

workers participating in a study conducted by Liberati et al. (2021), they reported facing a variety of moral dilemmas on a daily basis because they felt like they were letting their patients down at the level of delivering quality care. Despite moral injury not being a mental illness, these feelings of shame or guilt can lead to the development of mental health difficulties, post-traumatic stress disorder, and suicidal ideation (Greenberg et al., 2020).

In addition to the pandemic interfering with the work of healthcare professionals, it also interfered with their personal life. In a study by Frenkel et al. (2022), the results from an online survey of healthcare professionals showed that interference of workload with private life was a pivotal predictor of stress. According to another study by Liberati et al. (2021), staff who worked remotely felt that the boundaries of work and home life became blurred. This flexible boundary between work and home led individuals to work longer hours; they also had a lingering feeling of always being on-call. One participant stated that it was easy to work longer hours because the computer and phone were within arm's reach. As a result, the participants reported symptoms of burnout (Liberati et al., 2021). Another consequence of remote work was the lack of social interaction between staff. Healthcare workers have no opportunities for light-hearted conversations or small talk in between seeing clients or during downtime; they miss having a neighbor to turn to during a stressful day. One strength of this study was that there were many personal statements from the participants. Their exact words gave the reader a better understanding of their feelings and emotions. Overall, the literature reported high reports of stress, anxiety, and burnout among healthcare workers during the pandemic (Liberati et al., 2021).

Theme II: Overall Job Satisfaction Increases Resilience

Culleton (2021) did a qualitative phenomenological study to explore the experiences of ten OTs during the COVID-19 pandemic working at a Health Service Executive community and rehabilitation mental health services. The data was collected through semi-structured interviews and analyzed using reflexive thematic analysis. One of the themes identified in the findings was “holding on to what we do.” The OTs had a challenging time adjusting to the new method of the service delivery model, providing treatment in a different setting, and lacking resources. However, they still focused on motivating themselves to continue to provide the best quality mental health occupational therapy services during the pandemic—they did not want their patients to go untreated. Therefore, they had the intrinsic motivation to work through difficult times and adjusted to non-traditional methods of treatment in hopes of working toward better outcomes. Culleton (2021) stated that “there was a strong sense of desire among the occupational therapists to return to traditional observational methods normally used in mental health settings” (p. 5).

Another study conducted by Sung-Min and Han-Na (2021) discussed how occupational therapists were unsuccessful in staying within their profession caused by social anxiety and a decrease in job commitment due to the perceptions surrounding the disease. They stated that OTs treating COVID-19 patients with physical closeness created psychological anxiety and limited performance of their tasks due to fears of being infected by the disease. In addition, when OTs taught their clients proper behaviors in the process of cognitive and dysphagia rehabilitation, it increased the perceptual risk of

infection and therefore, increased anxiety. As a result, this significantly impacted OTs wanting to continue with their profession during the pandemic.

The literature has presented two opposing outcomes that OTs took during the pandemic. The negative outcome was that they had to discontinue their career, and the positive outcome was that they desired to stay in hopes of returning to the traditional way of treating their clients. Through our research, our goal was to help OTs discover which coping strategies were utilized in order to increase positive coping methods.

Theme III: Lack of Occupational Therapy Representation in Research Studies

A review of the literature shows that there was little research conducted on how the pandemic specifically affected occupational therapy practitioners. During our search of the literature, we found many articles about healthcare workers as a whole, but not specifically OTs. Instead, the most common healthcare professions listed in the literature were medical doctors, nurses, nurse practitioners, physician assistants, and therapists. We want to see how the mental health of OTs and their coping strategies differ from other health professionals. According to Sy et al. (2020), OTs supported people in the home and in the communities in order to sustain access to their occupations that affected their health, well-being, safety, and ability to adapt, while other health professionals were busy taking care of possibly COVID-positive patients. In another study conducted by Yang et al. (2021), they found that OTs, physical therapists (PTs), and nurses had different job stressors. They reminded the readers to be cautious about generalizing data to all healthcare workers. This further illustrates the need to research how OTs coped with the pandemic.

When researching further into the literature, many articles covered how the occupational therapy profession was affected instead of the effect on occupational therapy practitioners. Two articles we found that talked the mental health of occupational therapy practitioners were published by organizations in different countries. One study conducted by Sy et al. (2020) took place in the Philippines. The researchers used an online forum to share an online survey to gather information about Filipino OT's perceptions about the pandemic, identify strategies adopted by OTs to continue services, and to share future implications. The study did not specifically look at their mental health. The participants expressed the challenges of telehealth because of the lack of training, inadequate Wi-Fi, accountability, privacy, and confidentiality (Sy et al., 2020). An additional study by Yang et al. (2021), was conducted in Korea and the researchers surveyed workers in nursing care hospitals. They gathered a small sample size of 56 participants, and out of those 56 participants, 11 were OTs. In addition to OTs, the participants included PTs, nurses, radiographers, and administrative workers. This study made the distinction that OTs had a higher incidence of depression than PTs and nurses. In general, the study showed that 50% of the hospital workers reported symptoms of anxiety and 11% reported symptoms of depression (Yang et al., 2021). The main limitation of these two studies was the small sample size, and therefore, could not be generalized to the public. Each country had unique environmental, cultural, and socioeconomic factors that affected the results of the study.

In total, we only found one American study looking at the mental health and coping abilities of OTs during the pandemic. Coto et al. (2020) examined the impact of COVID-19 on allied health professions and found that in April 2020, Centers of

Medicare and Medicaid Services limited all elective, nonmedical services to reduce infections of COVID-19, causing many allied healthcare workers to lose their jobs. This was a unique stress factor that separated allied health professionals from the rest of the healthcare community. Data was collected via an online survey, receiving 1,171 responses from audiologists, social support services, speech-language pathologists, PT practitioners, and occupational therapy practitioners. Occupational therapy practitioners represented 9.4% of the participants. Their survey focused on how COVID-19 impacted the work environment, their mental health, access to personal protective equipment, and access to COVID tests. The results and discussion did not mention any specific details about occupational therapy practitioners but gave a unique insight into how allied health professionals were affected compared to other healthcare professionals (Coto et al., 2020).

Overall, the literature presented a common theme that occupational therapy practitioners were frequently grouped together with other healthcare professionals, despite experiencing different stressors. Furthermore, many of the studies were conducted in 2020, so we want to research and examine the changes that have occurred since then. We want to address the gap in the literature and focus on how occupational therapy practitioners in the United States were coping with the pandemic.

Statement of Purpose, Hypothesis and Research

For the purpose of our study, we focused on three aspects of the COVID-19 pandemic: to identify coping strategies used by occupational therapy practitioners, to understand the mental health of occupational therapy practitioners, and to discover coping strategies that were the most effective. With the data collected, we hope that

current and future occupational therapy practitioners can implement these strategies in their profession. For our hypothesis, we expect to find effective coping strategies from occupational therapy practitioners.

The population we targeted were occupational therapy practitioners during the COVID-19 pandemic. As for our intervention, we conducted an online survey using Google Forms with five demographic questions, twenty-eight questions regarding coping responses to stress using a Likert scale, and two open-ended questions. In addition, we compared our responses to other healthcare professionals. Finally, with all these points in mind, we want to answer the overall question: “How did occupational therapy practitioners cope during the COVID-19 pandemic?”

Theoretical Framework

For our theoretical framework, we aim to discover how occupational therapy practitioners adapted during the pandemic. Occupational adaptation is “the process and or outcome of the interaction between the person, occupation, and environment in response to the occupational challenge” (Walder et al., 2019). Occupational adaptation was developed at Texas Woman's University by Schkade and Schultz in 1992. Additionally, this frame of reference is considered a top-down, holistic, client-centered approach.

The main point of this theory is that the internal adaptation process improved functional outcomes and engagement in occupations. This theory focused on what is happening internally with the person. It uses activities and occupations during treatment to give opportunities to improve their internal adaptation process and to create a lifelong normative procedure. This theory uses occupation as a means to provide opportunities to

strengthen an adaptive response so that clients can improve functioning in occupational performance and create a greater sense of mastery over their environment.

Three predictable outcomes are observed when changing a person's internal adaptation process: improvement in self-initiation around impaired tasks, generalization, and improvement in relative mastery. This model observes the internal adaptation process and provides many opportunities for improvement in that adaptation process through engagement and meaningful activities. The intrinsic desire within the person for mastery motivates them to engage in an occupation. By utilizing occupations as a means and as an end, meaningful outcomes are produced.

Occupational Adaptation

The COVID-19 pandemic brought many disruptions to how healthcare professionals go about their day-to-day practices. Once the pandemic started, it made it difficult for occupational therapists to treat their patients through face-to-face consultations. Furthermore, OTs treated their patients in different settings, resulting in a lack of resources. As a result, many patients missed the needed treatments. However, OTs adjusted and adapted to the new forms of care as compared to the traditional face-to-face contact model.

Occupational therapists adapted by using telehealth as a service delivery model. OTs and COTAs were at the forefront of adapting telehealth service delivery methods. From April 2020 to January 2021, the results from the AOTA practice setting study suggested that clinical judgment was being used by OTs and COTAs to provide telehealth and virtual services (AOTA, 2022). OTs reported delivering approximately 8% of their services in hospitals and 15% in skilled nursing facilities using telehealth.

COTAs reported delivering approximately 10% of their services in skilled nursing facilities and 40% of their services in schools using telehealth and virtual methods. This was to mitigate the consequences of direct personal contact so telephone and videoconferencing consultations were implemented as an alternative.

Overall, we examined how occupational therapy practitioners faced occupational challenges in service delivery with a lack of resources throughout the pandemic. In addition, it presented that OTs had the intrinsic motivation to continue to strive through adversity and challenges during the pandemic. Occupational adaptation was successful in being applied to as a frame of reference for coping.

Methodology

Study Design and Sampling

The research used a mixed–method approach, including a descriptive, correlational, and phenomenological design. A Google Form survey was used to gather data from occupational therapy practitioners who practiced in their field at the time of our study. The main strategy to recruit participants was through convenient sampling. This was completed by sampling OTs in online communities via AOTA message boards, popular social media sites, and email groups. On each online platform, a digital flyer was attached with a brief description of the survey and a link to the survey (Appendix A). All participants needed to consent to the use of their responses by reading the online consent page on the first page of the survey and checking the “I agree” box to indicate the participants agree to proceed with the survey. The inclusion criteria was that participants must be either occupational therapists or occupational therapy assistants.

Data Collection

After reading the online consent page, checking “I agree”, and clicking next, the actual survey began as shown in Appendix B. The first part began with five demographic questions, asking questions regarding age, ethnicity, years of practice, title, and type of work setting. It was immediately followed by the Brief COPE inventory. The Brief COPE is a 28-question questionnaire designed to specifically assess a broad range of coping responses to stressors (Carver, 1997). Each coping item was rated based on a four-point Likert scale, where one was not doing the item at all, and four meant doing the item a lot. As shown in Table 1, two items correlated to a coping skill. The score of a certain coping skill was the sum of the Likert scale response from the two questions.

The questionnaire’s creator, Charles S. Carver, allowed the use of the inventory without specific permission if used for research or educational purposes (Carver, n.d.). We also asked two open-ended questions about the difficulties occupational therapy practitioners face in their current practice and personal life, as well as how they were able to cope with them. These questions aimed to get a more holistic picture of the possible environmental factors that that were not just limited to the questions about demographics. These questions were not optional and must be answered in one to three sentences in order to complete the survey.

Rationale for Using the Brief COPE Inventory

The Brief COPE has been one of the most used coping scales to describe occupational and personal coping skills (Kato, 2013). For the past two years, the Brief COPE has also been used as the gold standard in measuring the coping skills of health professionals since the COVID-19 pandemic (Abdul Rahman et al., 2021). This

advantage allowed us to compare the results of the study with others that also utilize the same inventory. Gillen et al. (2022) surveyed UK allied health professionals from November 2020 through February 2021. Despite the survey taking part earlier in the pandemic, we decided a comparison of coping skills still had merit. More specifically, looking at the differences in how health professionals, including OTs, coping skills changed over course of the pandemic. Because the Brief COPE was limited to the time of the survey date, we expect the coping skills between this study and Gillen et al.'s (2022) study to vary greatly.

The tool was also shown in several studies to have internal consistency, test-retest reliability, and validity (Yusoff et al., 2010). An additional benefit was that the Brief COPE inventory did not require permission from the author. As a result, using the Brief COPE instead of creating an original scale allowed us to compare the results to other health professionals and increased the rigor and objectivity of the results.

Quantitative Data Analysis

After completing data collection in September 2022, analysis occurred with both quantitative and qualitative data. The quantitative consisted of the independent variable, which would be years of experience, age, ethnicity, type of practitioner, and setting. The dependent variable was the mean score of the Brief COPE results. All of the results were depicted in several bar graphs to compare the results of the mean score within each demographic subtype. Gillen et al.'s (2022) Brief COPE mean scores in the study were used to compare them with the study results.

Independent T-tests were also administered between the categories within each independent variable in relation to their Brief COPE score to see if there was a significant

difference in the scores. Seeing a significant difference can demonstrate environmental and personal factors potentially having a role in developing certain coping skills.

The quantitative data analysis was done through a statistical software platform called the Statistical Package for the Social Sciences (SPSS). SPSS was used to streamline the process of creating graphs and performing statistical analysis on the collected data. Other statistical tools were considered if the tool was inaccessible at the time of analysis.

Qualitative Data Analysis

The qualitative data comes from the two final open-ended questions of the survey. These responses were coded for common themes. The responses to the survey were transferred over to a spreadsheet. From there, the data was inputted and coded using Dedoose, a program used to analyze qualitative and mixed methods research.

The qualitative data was examined using a phenomenological approach. This approach focused on people's experiences and how they perceived their immediate world (Taylor, 2017). We believe this approach was suitable for the study because viewing the experience holistically and through the eyes of the practitioner gave answers of their motivation and how their experience was shaped by their immediate concerns.

Results

The study rationale, methodology, and instruments were reviewed and approved by the Institutional Review Board on August 9, 2022, as seen in Appendix D. A total of 33 responses were collected by September 7, 2022 (see Appendix E). However, because the scope of the study is limited to 30, only the first 30 participants who responded were

considered. The 30 participants all fulfilled the inclusion criteria, and their responses were analyzed.

Quantitative Data

From the 30 respondents, “acceptance” was chosen as a common coping strategy during the pandemic with a mean of 6.20 (Table 2). Additionally, “substance use” was the least common coping strategy with a total mean of 2.43. Multiple t-tests were performed in all categories, showing that the difference in the scores of the Brief COPE responses was statistically insignificant ($p>0.05$). The occupational therapy practitioners that were aged 21-30, chose to utilize “acceptance” as a coping strategy, with a mean of 6 (see Table 3). The occupational therapy practitioners aged between 41-50, also chose “acceptance” with a mean of 6.33.

The occupational therapy practitioners that were Caucasian chose “acceptance” as their primary coping strategy during the pandemic, with a mean of 6.21 (see Table 4). Within the Latino or Hispanic group, “actively cope” was reported to be the primary coping strategy during the pandemic with a mean of 7. The occupational therapy practitioners that were Asian chose “acceptance” as a primary coping strategy for the pandemic, with a mean of 6.43. The occupational therapy practitioners with zero to five years of experience chose “acceptance” as a coping strategy with a mean of 5.69 (see Table 5). Finally, occupational therapy practitioners with 6-10 years of experience chose “acceptance” as a coping strategy during the pandemic, with a mean of 6.60.

For the 26 OTs, the majority chose “acceptance” as a coping strategy, with a mean of 6.2 (see Table 6). The least common response was utilizing substances to cope during the pandemic, with a mean of 2.23. As for the COTAs, they chose religion as a

copied strategy with a mean of 6. The least picked responses in the survey were denial, behavioral disengagement, and self-blame, with a mean of 3. Lastly, the occupational therapy practitioners with more than two settings chose acceptance to cope, with a mean of 6 (see Table 7). The respondents with a hospital setting chose "acceptance", with a mean of 5.80. The respondents in an outpatient setting chose "active coping" and "acceptance" as coping strategies, with a mean of 5.25.

Qualitative Data

The two open-ended questions in our survey asked the respondents to describe any difficulties they currently face at work and at home due to COVID-19, and to describe the coping skills they use when facing their difficulties. 13 common themes were identified from the responses answering the type of difficulties faced and 15 common themes were identified from the responses answering the type of coping skills used.

Of the 16 occupational therapy practitioners with under five years of experience, five of them interacted with friends or families during the pandemic. Three occupational therapy practitioners with 21-30 years of experience had no difficulties during the pandemic. Finally, occupational therapy practitioners who had more than 30 years of experience had responses that fell under "interacted with coworkers and adapted to the environment". Of the 12 occupational therapy practitioners between 21 to 30 years old, four interacted with friends and families. Aged between 31 to 40, three respondents utilized exercise during the pandemic. As for occupational therapy practitioners aged 50 and above, three stated that they had no difficulties during the pandemic.

The occupational therapy practitioners that were Caucasian interacted with "coworkers and staff, practiced acceptance and kept working during the pandemic." As

for the Latino or Hispanic group, two stated that “they had no difficulties coping.” Finally, for the Asian group, they “interacted with friends and family”. Of the 26 OTs six “interacted with friends and families”, and “accepted” the COVID-19 pandemic. Out of four OTAs, two of them “exercised” during the pandemic. The rest of them were dispersed evenly by “engaging in hobbies, adapting to the environment, and kept praying.”

Lastly, five occupational therapy practitioners in an outpatient setting focused on “finding distractions, and another kept working.” The ten occupational therapy practitioners in a hospital setting chose to “exercise, interacting with coworkers, staff, family, and friends.” Overall, the most common responses to what difficulties our respondents currently face were staff shortages, change in workflow, the spread of COVID-19 to others, limited facility support, and burnout. Other responses include restlessness, lack of community support, reduced income, work-life balance, work apathy, increased workload, poor work conditions, and no difficulties. Coping mechanisms occupational therapy practitioners currently use in response to those difficulties were “interacting with friends and family, exercising, acceptance, interacting with coworkers and staff, and working.” Other less common coping mechanisms were “therapy, praying, and finding distractions.”

Comparison of Brief COPE Inventory Results to Gillen

Gillen et al. (2022) surveyed their participants with a modified version of the Brief COPE, leaving out questions that scored for self-distraction, denial, humor, acceptance, and religion. They surveyed their participants in two phases, with phase one

ranging from May through July 2020 and phase two ranging from November through February 2021. Phase 2's scores were used to compare with those from this study.

The mean of all ten coping skills scores in phase one and phase two was higher than in this study. The most significant difference in scores was in acceptance, active coping, and self-blame. On the other hand, the scores with the slightest differences were instrumental support, behavioral engagement, and emotional support.

Discussion

Changes in workflow and staff shortages were prevalent problems for most occupational therapy practitioners in this study. These results were consistent with previous studies by Liberati et al. (2021) and Frenkel et al. (2022), showing how environmental and policy changes impact health professionals negatively. The fear of spreading COVID-19 was a constant reality for occupational therapy practitioners in close contact with their clients and other professionals. Spreading the virus has financial and social impacts, leading to burnout and mental health decline. Despite the difference in demographics between occupational therapy practitioners, we saw that socialization between family, friends, and coworkers was a universal coping strategy. Social participation provided an outlet for OTs to reduce stress and increase self-worth through encouragement, validation, and sharing a common bond. It also allows one to express their thoughts aloud and allows for feedback from others.

The Brief COPE revealed general coping skills that the participants used that may not have been explicitly expressed in their open-ended responses. As mentioned, the dominant coping strategies used were acceptance, positive reframing, and planning. These strategies aligned with the Occupational Adaptation frame of reference used by

occupational therapy practitioners in clinical settings with their clients. As previously mentioned, Occupational Adaptation uses occupation to strengthen adaptive responses and improve mastery over their environment. Thus, being able to persevere through adversity was a toolset built in the occupational therapy profession that the occupational therapy practitioners themselves can use to achieve occupational balance.

Lastly, comparisons to Gillen et al. (2022) show a possible effect of the time frame of the pandemic and the differences in coping strategies between professions. These factors cannot be ruled out and must be considered an interaction between individual life experiences and their environment. For example, the severity and prevalence of the virus may play a significant role in why self-blame was one of the most used coping skills by Gillen et al. (2022).

Possible Limitations of the Project

The study was limited by participants using the recruitment material platforms. Occupational therapy practitioners with no access to the platforms or who used the targeted platforms would not be able to discover the recruitment material to participate in the study. Because of time and financial constraints, we prioritize gathering data through convenient sampling at the expense of obtaining skewed responses that favor specific demographics. Another unpredictable factor was the algorithm impacted the level of visibility for the recruitment material for some social media platforms. Additionally, since the participants were anonymous with no identifiable markers such as licenses, it was difficult to verify if all participants were practicing professionals in occupational therapy.

A limitation on the inventory items due to the clarity of specific questions may have caused some confusion in participants' answers. For example, item two of the Brief COPE states, "I've been concentrating my efforts on doing something about the situation I'm in". Participants may perceive the question as about the pandemic's peak and early stages rather than the current ongoing situation. Item 21 states, "I've been expressing my negative feelings," which was also subject to the same limitation. The Brief COPE inventory provided by Carver (1997) was beneficial for this study due to convenience and a limited time frame for data collection. However, its inventory of questions may need to be modified for future studies that employ the same methods when collecting future results.

Time constraints when collecting data were a limiting factor for sampling participants. Our study captured only a month during the ongoing pandemic. The research would benefit from a longer time frame as data collected without this limitation could provide further analysis of the ongoing changes of practitioners as the pandemic progresses throughout the time and seasons. Seasonal changes are most useful since they can directly influence the number of patients affected by COVID-19 and the stressors of the intake of new patients that occupational therapists have to serve.

COVID-19 was still an evolving phenomenon, and there was a lack of literature on the coping skills of occupational therapy practitioners during the pandemic that can support the validity and reliability of the study as a whole; we were unable to prove the rigor of our survey tool without further use. However, we hope that incorporating the Brief COPE, a widely used inventory to survey the coping skills of health professionals

during the pandemic, demonstrated some external validity compared to other studies and allowed future research to further research and develop this topic.

Ethical and Legal Considerations

Our research posed a minimal risk for participants. The only identifiable risk was reliving negative feelings and emotions about their experience during the pandemic. In addition, we did not collect any person-identifying information such as the participant's name, birthdate, address, or email. They remained completely anonymous, and we also coded open-ended questions to reduce further identification. The information asked in the survey, as seen in Appendix B, related to their career as occupational therapy professionals. All information was held in a secured Google Forms account to which only the members of the group and the thesis advisor had access.

Furthermore, when the participant was presented with the survey link, the first item that appeared was the consent form, as shown in Appendix C. The consent form informed the participants of who was conducting the study, the survey topic, and who they could contact for further questions. When the participant submits the survey, they consent to participate in our research study. Additionally, after the completion of the data collection, further access to the survey was locked to prevent unauthorized access to the form.

Information collected from the Brief COPE inventory was subjective in interpretation. Therefore, this study should not be used as evidence of the fact in any legal proceedings but as informative research into the topic of coping during COVID-19 by occupational therapy professionals. Furthermore, results from this study provide a

base for future research on the subject since few literary sources have provided results on the coping skills of occupational therapy professionals during the ongoing pandemic.

Conclusion

The study aimed to identify occupational therapy practitioners' coping strategies, understand their mental health, and discover the most effective coping strategies they used. Our study used a survey to collect data from occupational therapy practitioners about their coping styles. A comprehensive look into the life of the occupational therapy practitioner was gained using five demographic questions, twenty-eight questions regarding coping responses to stress using a Likert scale, and two open-ended questions.

Furthermore, there were many studies conducted on healthcare workers, but there was not a lot of information explicitly looking at how OTs coped with the pandemic. It is essential to address the differences between healthcare workers because each profession experiences different stressors that other professions may not experience (Yang et al., 2021). The lack of information about the effects of the pandemic on occupational therapy practitioners was the gap in the literature we aim to address with our study. In our results, occupational therapy practitioners used coping mechanisms in response to those difficulties by interacting with friends and family, exercising, practicing acceptance, interacting with coworkers and staff, and working.

The COVID-19 pandemic impacted many healthcare professionals' lives due to the virus's severity. Many healthcare workers felt the strain of the pandemic because of the rapid changes in the healthcare system, possible infection through close contact with patients, and increased work hours. The study results revealed that many healthcare professionals reported staff shortages, changes in workflow, the spread of COVID-19 to

others, limited facility support, and burnout. On the other hand, we saw that socialization between family, friends, and coworkers was a universal coping strategy. Additionally, acceptance, positive reframing, and planning were the most widely used coping mechanisms OTs used to adapt to the changing and demanding environment of COVID-19 and to work under pandemic conditions. OTs have shown resilience in adapting to the workplace with their knowledge and training in therapy. For future research, data from a longitudinal study can provide insight into the effectiveness of coping mechanisms throughout the current pandemic.

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Table 1*Correspondence of Coping Skills With Question Number in Survey.*

Coping Skills	Question Number
Self-distraction	1,9
Active-coping	2,7
Denial	3,8
Substance use	4,11
Use of emotional support	5,15
Use of instrumental support	10,23
Behavioral disengagement	6,16
Venting	9,21
Positive reframing	12,17
Planning	14,25
Humor	18,28
Acceptance	20,24
Religion	22,27
Self-blame	13,26

Table 2*Brief COPE Coping Skills Mean Scores*

Coping Skills	Mean Score
Self-distraction	4.67
Active-coping	5
Denial	2.53
Substance use	2.43
Use of emotional support	4.77
Use of instrumental support	4.47
Behavioral disengagement	2.73
Venting	3.97
Positive reframing	5.13
Planning	5.07
Humor	4.1
Acceptance	6.2
Religion	3.8
Self-blame	3.23

Table 3

Descriptive Analysis of Brief COPE Results by Age

	Age	N	Mean	Std. Deviation	Std. Error	95% Confidence Interval for Mean		Minimum
						Lower Bound	Upper Bound	
Self-distraction	21-30	12	4.83	1.53	.44	3.86	5.80	2.00
	31-40	9	4.56	1.13	.38	3.69	5.42	3.00
	41-50	3	4.00	2.00	1.15	-.97	8.97	2.00
	50+	6	4.83	1.17	.48	3.61	6.06	3.00
	Total	30	4.67	1.35	.25	4.16	5.17	2.00
Active coping	21-30	12	5.25	2.09	.60	3.92	6.58	2.00
	31-40	9	4.00	1.32	.44	2.98	5.02	2.00
	41-50	3	5.33	1.53	.88	1.54	9.13	4.00
	50+	6	5.83	1.17	.48	4.61	7.06	4.00
	Total	30	5.00	1.74	.32	4.35	5.65	2.00
Denial	21-30	12	2.50	1.00	.29	1.86	3.14	2.00
	31-40	9	2.33	1.00	.33	1.56	3.10	2.00
	41-50	3	2.67	.58	.33	1.23	4.10	2.00
	50+	6	2.83	.98	.40	1.80	3.87	2.00
	Total	30	2.53	.94	.17	2.18	2.88	2.00
Substance use	21-30	12	2.17	.58	.17	1.80	2.53	2.00
	31-40	9	2.67	1.66	.55	1.39	3.94	2.00
	41-50	3	3.00	1.73	1.00	-1.30	7.30	2.00
	50+	6	2.33	.82	.33	1.48	3.19	2.00
	Total	30	2.43	1.14	.21	2.01	2.86	2.00
Use of emotional support	21-30	12	5.17	2.12	.61	3.82	6.52	2.00
	31-40	9	4.78	1.79	.60	3.40	6.15	2.00
	41-50	3	4.33	2.52	1.45	-1.92	10.58	2.00
	50+	6	4.17	1.33	.54	2.77	5.56	2.00
	Total	30	4.77	1.87	.34	4.07	5.46	2.00
Use of instrumental support	21-30	12	4.75	1.71	.49	3.66	5.84	2.00
	31-40	9	4.33	1.58	.53	3.12	5.55	2.00
	41-50	3	4.33	2.52	1.45	-1.92	10.58	2.00
	50+	6	4.17	1.72	.70	2.36	5.97	2.00
	Total	30	4.47	1.68	.31	3.84	5.09	2.00
Behavioral disengagement	21-30	12	2.33	.65	.19	1.92	2.75	2.00
	31-40	9	3.11	1.27	.42	2.14	4.09	2.00
	41-50	3	4.00	2.65	1.53	-2.57	10.57	2.00
	50+	6	2.33	.52	.21	1.79	2.88	2.00
	Total	30	2.73	1.20	.22	2.28	3.18	2.00
Venting	21-30	12	3.67	1.07	.31	2.98	4.35	2.00
	31-40	9	4.44	1.88	.63	3.00	5.89	2.00
	41-50	3	5.00	1.00	.58	2.52	7.48	4.00
	50+	6	3.33	1.21	.49	2.06	4.60	2.00
	Total	30	3.97	1.43	.26	3.43	4.50	2.00
Positive reframing	21-30	12	4.83	2.33	.67	3.35	6.31	2.00
	31-40	9	4.67	1.94	.65	3.18	6.16	2.00
	41-50	3	5.67	1.53	.88	1.87	9.46	4.00
	50+	6	6.17	.98	.40	5.13	7.20	5.00
	Total	30	5.13	1.94	.35	4.41	5.86	2.00
Planning	21-30	12	5.17	1.95	.56	3.93	6.40	2.00
	31-40	9	4.44	1.59	.53	3.22	5.67	2.00
	41-50	3	5.33	.58	.33	3.90	6.77	5.00

	Age	N	Mean	Std. Deviation	Std. Error	95% Confidence Interval for Mean		Minimum
						Lower Bound	Upper Bound	
	50+	6	5.67	2.07	.84	3.50	7.83	2.00
	Total	30	5.07	1.76	.32	4.41	5.72	2.00
Humor	21-30	12	3.75	1.86	.54	2.57	4.93	2.00
	31-40	9	4.33	1.66	.55	3.06	5.61	2.00
	41-50	3	4.67	2.31	1.33	-1.07	10.40	2.00
	50+	6	4.17	1.83	.75	2.24	6.09	2.00
	Total	30	4.10	1.77	.32	3.44	4.76	2.00
Acceptance	21-30	12	6.00	1.95	.56	4.76	7.24	2.00
	31-40	9	5.89	1.27	.42	4.91	6.86	4.00
	41-50	3	6.33	1.53	.88	2.54	10.13	5.00
	50+	6	7.00	.89	.37	6.06	7.94	6.00
	Total	30	6.20	1.54	.28	5.62	6.78	2.00
Religion	21-30	12	3.00	1.76	.51	1.88	4.12	2.00
	31-40	9	3.78	2.11	.70	2.16	5.40	2.00
	41-50	3	4.00	2.00	1.15	-.97	8.97	2.00
	50+	6	5.33	1.97	.80	3.27	7.40	3.00
	Total	30	3.80	2.02	.37	3.04	4.56	2.00
Self-blame	21-30	12	3.08	1.16	.34	2.34	3.82	2.00
	31-40	9	3.56	1.51	.50	2.40	4.72	2.00
	41-50	3	4.00	1.73	1.00	-.30	8.30	2.00
	50+	6	2.67	.82	.33	1.81	3.52	2.00
	Total	30	3.23	1.28	.23	2.76	3.71	2.00

Table 4

Descriptive Analysis of Brief COPE Results by Ethnicity

	Ethnicity	N	Mean	Std. Deviation	Std. Error	95% Confidence Interval for Mean		Minimum
						Lower Bound	Upper Bound	
Self-distraction	Caucasian	19	4.89	1.41	.32	4.22	5.57	2.00
	Latino or Hispanic	2	4.00	2.83	2.00	-21.41	29.41	2.00
	Asian	7	4.29	.95	.36	3.41	5.17	3.00
	Prefer not to say	1	4.00	NaN	NaN	NaN	NaN	4.00
	Other	1	5.00	NaN	NaN	NaN	NaN	5.00
	Total	30	4.67	1.35	.25	4.16	5.17	2.00
Active coping	Caucasian	19	5.21	1.78	.41	4.35	6.07	2.00
	Latino or Hispanic	2	7.00	.00	.00	7.00	7.00	7.00
	Asian	7	4.43	1.40	.53	3.14	5.72	2.00
	Prefer not to say	1	3.00	NaN	NaN	NaN	NaN	3.00
	Other	1	3.00	NaN	NaN	NaN	NaN	3.00
	Total	30	5.00	1.74	.32	4.35	5.65	2.00
Denial	Caucasian	19	2.53	.90	.21	2.09	2.96	2.00
	Latino or Hispanic	2	3.50	.71	.50	-2.85	9.85	3.00
	Asian	7	2.43	1.13	.43	1.38	3.48	2.00
	Prefer not to say	1	2.00	NaN	NaN	NaN	NaN	2.00
	Other	1	2.00	NaN	NaN	NaN	NaN	2.00
	Total	30	2.53	.94	.17	2.18	2.88	2.00
Substance use	Caucasian	19	2.58	1.35	.31	1.93	3.23	2.00
	Latino or Hispanic	2	2.00	.00	.00	2.00	2.00	2.00
	Asian	7	2.00	.00	.00	2.00	2.00	2.00
	Prefer not to say	1	2.00	NaN	NaN	NaN	NaN	2.00
	Other	1	4.00	NaN	NaN	NaN	NaN	4.00
	Total	30	2.43	1.14	.21	2.01	2.86	2.00
Use of emotional support	Caucasian	19	5.11	1.82	.42	4.23	5.98	2.00
	Latino or Hispanic	2	3.00	1.41	1.00	-9.71	15.71	2.00
	Asian	7	4.29	1.89	.71	2.54	6.03	2.00
	Prefer not to say	1	3.00	NaN	NaN	NaN	NaN	3.00
	Other	1	7.00	NaN	NaN	NaN	NaN	7.00
	Total	30	4.77	1.87	.34	4.07	5.46	2.00
Use of instrumental support	Caucasian	19	4.63	1.50	.34	3.91	5.35	2.00
	Latino or Hispanic	2	4.00	2.83	2.00	-21.41	29.41	2.00
	Asian	7	4.43	2.07	.78	2.51	6.34	2.00
	Prefer not to say	1	2.00	NaN	NaN	NaN	NaN	2.00
	Other	1	5.00	NaN	NaN	NaN	NaN	5.00
	Total	30	4.47	1.68	.31	3.84	5.09	2.00
Behavioral disengagement	Caucasian	19	2.84	1.42	.33	2.16	3.53	2.00
	Latino or Hispanic	2	2.00	.00	.00	2.00	2.00	2.00

	Ethnicity	N	Mean	Std. Deviation	Std. Error	95% Confidence Interval for Mean		Minimum
						Lower Bound	Upper Bound	
	Asian	7	2.57	.53	.20	2.08	3.07	2.00
	Prefer not to say	1	2.00	NaN	NaN	NaN	NaN	2.00
	Other	1	4.00	NaN	NaN	NaN	NaN	4.00
	Total	30	2.73	1.20	.22	2.28	3.18	2.00
Venting	Caucasian	19	4.32	1.53	.35	3.58	5.05	2.00
	Latino or Hispanic	2	3.00	1.41	1.00	-9.71	15.71	2.00
	Asian	7	3.57	.98	.37	2.67	4.47	2.00
	Prefer not to say	1	2.00	NaN	NaN	NaN	NaN	2.00
	Other	1	4.00	NaN	NaN	NaN	NaN	4.00
	Total	30	3.97	1.43	.26	3.43	4.50	2.00
Positive reframing	Caucasian	19	5.11	2.00	.46	4.14	6.07	2.00
	Latino or Hispanic	2	6.50	.71	.50	.15	12.85	6.00
	Asian	7	5.29	1.98	.75	3.46	7.11	3.00
	Prefer not to say	1	5.00	NaN	NaN	NaN	NaN	5.00
	Other	1	2.00	NaN	NaN	NaN	NaN	2.00
	Total	30	5.13	1.94	.35	4.41	5.86	2.00
Planning	Caucasian	19	5.32	1.77	.41	4.46	6.17	2.00
	Latino or Hispanic	2	6.50	.71	.50	.15	12.85	6.00
	Asian	7	4.71	1.50	.57	3.33	6.10	2.00
	Prefer not to say	1	2.00	NaN	NaN	NaN	NaN	2.00
	Other	1	3.00	NaN	NaN	NaN	NaN	3.00
	Total	30	5.07	1.76	.32	4.41	5.72	2.00
Humor	Caucasian	19	3.74	1.73	.40	2.90	4.57	2.00
	Latino or Hispanic	2	5.50	.71	.50	-.85	11.85	5.00
	Asian	7	4.14	1.57	.59	2.69	5.60	2.00
	Prefer not to say	1	4.00	NaN	NaN	NaN	NaN	4.00
	Other	1	8.00	NaN	NaN	NaN	NaN	8.00
	Total	30	4.10	1.77	.32	3.44	4.76	2.00
Acceptance	Caucasian	19	6.21	1.58	.36	5.45	6.97	2.00
	Latino or Hispanic	2	6.00	1.41	1.00	-6.71	18.71	5.00
	Asian	7	6.43	1.62	.61	4.93	7.93	4.00
	Prefer not to say	1	4.00	NaN	NaN	NaN	NaN	4.00
	Other	1	7.00	NaN	NaN	NaN	NaN	7.00
	Total	30	6.20	1.54	.28	5.62	6.78	2.00
Religion	Caucasian	19	3.68	2.00	.46	2.72	4.65	2.00
	Latino or Hispanic	2	4.50	2.12	1.50	-14.56	23.56	3.00
	Asian	7	4.14	2.48	.94	1.85	6.44	2.00
	Prefer not to say	1	4.00	NaN	NaN	NaN	NaN	4.00
	Other	1	2.00	NaN	NaN	NaN	NaN	2.00
	Total	30	3.80	2.02	.37	3.04	4.56	2.00
Self-blame	Caucasian	19	3.42	1.26	.29	2.81	4.03	2.00
	Latino or Hispanic	2	2.00	.00	.00	2.00	2.00	2.00
	Asian	7	3.29	1.50	.57	1.90	4.67	2.00

Ethnicity	N	Mean	Std. Deviation	Std. Error	95% Confidence Interval for Mean		Minimum
					Lower Bound	Upper Bound	
Prefer not to say	1	2.00	NaN	NaN	NaN	NaN	2.00
Other	1	3.00	NaN	NaN	NaN	NaN	3.00
Total	30	3.23	1.28	.23	2.76	3.71	2.00

Table 5

Descriptive Analysis of Brief COPE Results by Years of Experience

	Years of Experience	N	Mean	Std. Deviation	Std. Error	95% Confidence Interval for Mean		Minimum
						Lower Bound	Upper Bound	
Self-distraction	0-5	16	4.69	1.45	.36	3.92	5.46	2.00
	6-10	5	4.00	1.41	.63	2.24	5.76	2.00
	11-20	3	5.33	1.15	.67	2.46	8.20	4.00
	21-30	3	4.67	1.53	.88	.87	8.46	3.00
	More than 30	3	5.00	1.00	.58	2.52	7.48	4.00
	Total	30	4.67	1.35	.25	4.16	5.17	2.00
Active coping	0-5	16	4.75	1.77	.44	3.81	5.69	2.00
	6-10	5	5.40	2.41	1.08	2.41	8.39	2.00
	11-20	3	4.00	1.00	.58	1.52	6.48	3.00
	21-30	3	6.00	1.00	.58	3.52	8.48	5.00
	More than 30	3	5.67	1.53	.88	1.87	9.46	4.00
	Total	30	5.00	1.74	.32	4.35	5.65	2.00
Denial	0-5	16	2.38	.89	.22	1.90	2.85	2.00
	6-10	5	2.20	.45	.20	1.64	2.76	2.00
	11-20	3	3.33	1.53	.88	-.46	7.13	2.00
	21-30	3	3.00	1.00	.58	.52	5.48	2.00
	More than 30	3	2.67	1.15	.67	-.20	5.54	2.00
	Total	30	2.53	.94	.17	2.18	2.88	2.00
Substance use	0-5	16	2.19	.54	.14	1.90	2.48	2.00
	6-10	5	2.00	.00	.00	2.00	2.00	2.00
	11-20	3	4.67	2.52	1.45	-1.58	10.92	2.00
	21-30	3	2.00	.00	.00	2.00	2.00	2.00
	More than 30	3	2.67	1.15	.67	-.20	5.54	2.00
	Total	30	2.43	1.14	.21	2.01	2.86	2.00
Use of emotional support	0-5	16	4.94	1.91	.48	3.92	5.96	2.00
	6-10	5	4.40	2.61	1.17	1.16	7.64	2.00
	11-20	3	5.67	1.53	.88	1.87	9.46	4.00
	21-30	3	4.67	1.15	.67	1.80	7.54	4.00
	More than 30	3	3.67	1.53	.88	-.13	7.46	2.00
	Total	30	4.77	1.87	.34	4.07	5.46	2.00
Use of instrumental support	0-5	16	4.44	1.59	.40	3.59	5.28	2.00
	6-10	5	4.40	2.30	1.03	1.54	7.26	2.00
	11-20	3	5.33	1.53	.88	1.54	9.13	4.00
	21-30	3	4.33	2.08	1.20	-.84	9.50	2.00
	More than 30	3	4.00	1.73	1.00	-.30	8.30	3.00
	Total	30	4.47	1.68	.31	3.84	5.09	2.00
Behavioral disengagement	0-5	16	2.56	.89	.22	2.09	3.04	2.00
	6-10	5	2.40	.89	.40	1.29	3.51	2.00
	11-20	3	5.00	2.00	1.15	.03	9.97	3.00
	21-30	3	2.33	.58	.33	.90	3.77	2.00
	More than 30	3	2.33	.58	.33	.90	3.77	2.00
	Total	30	2.73	1.20	.22	2.28	3.18	2.00
Venting	0-5	16	3.88	1.36	.34	3.15	4.60	2.00

	Years of Experience	N	Mean	Std. Deviation	Std. Error	95% Confidence Interval for Mean		Minimum
						Lower Bound	Upper Bound	
	6-10	5	4.20	1.92	.86	1.81	6.59	2.00
	11-20	3	5.33	.58	.33	3.90	6.77	5.00
	21-30	3	3.33	1.53	.88	-.46	7.13	2.00
	More than 30	3	3.33	1.15	.67	.46	6.20	2.00
	Total	30	3.97	1.43	.26	3.43	4.50	2.00
Positive reframing	0-5	16	4.31	2.06	.51	3.22	5.41	2.00
	6-10	5	6.20	1.79	.80	3.98	8.42	4.00
	11-20	3	5.67	1.53	.88	1.87	9.46	4.00
	21-30	3	6.33	1.15	.67	3.46	9.20	5.00
	More than 30	3	6.00	1.00	.58	3.52	8.48	5.00
	Total	30	5.13	1.94	.35	4.41	5.86	2.00
Planning	0-5	16	4.69	1.70	.43	3.78	5.59	2.00
	6-10	5	5.60	2.19	.98	2.88	8.32	2.00
	11-20	3	5.00	.00	.00	5.00	5.00	5.00
	21-30	3	6.00	1.00	.58	3.52	8.48	5.00
	More than 30	3	5.33	3.06	1.76	-2.26	12.92	2.00
	Total	30	5.07	1.76	.32	4.41	5.72	2.00
Humor	0-5	16	4.06	1.73	.43	3.14	4.98	2.00
	6-10	5	3.80	2.05	.92	1.26	6.34	2.00
	11-20	3	4.67	2.31	1.33	-1.07	10.40	2.00
	21-30	3	5.00	2.00	1.15	.03	9.97	3.00
	More than 30	3	3.33	1.53	.88	-.46	7.13	2.00
	Total	30	4.10	1.77	.32	3.44	4.76	2.00
Acceptance	0-5	16	5.69	1.74	.44	4.76	6.61	2.00
	6-10	5	6.60	1.34	.60	4.93	8.27	5.00
	11-20	3	6.67	1.15	.67	3.80	9.54	6.00
	21-30	3	6.67	.58	.33	5.23	8.10	6.00
	More than 30	3	7.33	1.15	.67	4.46	10.20	6.00
	Total	30	6.20	1.54	.28	5.62	6.78	2.00
Religion	0-5	16	3.19	1.87	.47	2.19	4.18	2.00
	6-10	5	4.00	2.35	1.05	1.09	6.91	2.00
	11-20	3	3.67	1.53	.88	-.13	7.46	2.00
	21-30	3	5.00	2.65	1.53	-1.57	11.57	3.00
	More than 30	3	5.67	1.53	.88	1.87	9.46	4.00
	Total	30	3.80	2.02	.37	3.04	4.56	2.00
Self-blame	0-5	16	3.19	1.17	.29	2.57	3.81	2.00
	6-10	5	3.00	1.73	.77	.85	5.15	2.00
	11-20	3	5.00	.00	.00	5.00	5.00	5.00
	21-30	3	2.33	.58	.33	.90	3.77	2.00
	More than 30	3	3.00	1.00	.58	.52	5.48	2.00
	Total	30	3.23	1.28	.23	2.76	3.71	2.00

Table 6

Descriptive Analysis of Brief COPE Results by Type of Practitioner

Type	N	Mean	Std. Deviation	Std. Error	95% Confidence Interval for Mean		Minimum	
					Lower Bound	Upper Bound		
Self-distraction	Occupational Therapist	26	4.73	1.31	.26	4.20	5.26	2.00
	Occupational Therapy Assistant	4	4.25	1.71	.85	1.53	6.97	2.00
	Total	30	4.67	1.35	.25	4.16	5.17	2.00
Active coping	Occupational Therapist	26	5.00	1.77	.35	4.29	5.71	2.00
	Occupational Therapy Assistant	4	5.00	1.83	.91	2.09	7.91	3.00
	Total	30	5.00	1.74	.32	4.35	5.65	2.00
Denial	Occupational Therapist	26	2.46	.86	.17	2.11	2.81	2.00
	Occupational Therapy Assistant	4	3.00	1.41	.71	.75	5.25	2.00
	Total	30	2.53	.94	.17	2.18	2.88	2.00
Substance use	Occupational Therapist	26	2.23	.71	.14	1.94	2.52	2.00
	Occupational Therapy Assistant	4	3.75	2.36	1.18	-.01	7.51	2.00
	Total	30	2.43	1.14	.21	2.01	2.86	2.00
Use of emotional support	Occupational Therapist	26	4.92	1.83	.36	4.18	5.66	2.00
	Occupational Therapy Assistant	4	3.75	2.06	1.03	.47	7.03	2.00
	Total	30	4.77	1.87	.34	4.07	5.46	2.00
Use of instrumental support	Occupational Therapist	26	4.58	1.70	.33	3.89	5.26	2.00
	Occupational Therapy Assistant	4	3.75	1.50	.75	1.36	6.14	2.00
	Total	30	4.47	1.68	.31	3.84	5.09	2.00
Behavioral disengagement	Occupational Therapist	26	2.69	1.19	.23	2.21	3.17	2.00
	Occupational Therapy Assistant	4	3.00	1.41	.71	.75	5.25	2.00
	Total	30	2.73	1.20	.22	2.28	3.18	2.00
Venting	Occupational Therapist	26	4.08	1.41	.28	3.51	4.65	2.00
	Occupational Therapy Assistant	4	3.25	1.50	.75	.86	5.64	2.00
	Total	30	3.97	1.43	.26	3.43	4.50	2.00
Positive reframing	Occupational Therapist	26	5.08	2.06	.40	4.25	5.91	2.00
	Occupational Therapy Assistant	4	5.50	1.00	.50	3.91	7.09	4.00
	Total	30	5.13	1.94	.35	4.41	5.86	2.00

Type	N	Mean	Std. Deviation	Std. Error	95% Confidence Interval for Mean		Minimum	
					Lower Bound	Upper Bound		
Planning	Occupational Therapist	26	5.19	1.77	.35	4.48	5.91	2.00
	Occupational Therapy Assistant	4	4.25	1.71	.85	1.53	6.97	2.00
	Total	30	5.07	1.76	.32	4.41	5.72	2.00
Humor	Occupational Therapist	26	4.00	1.77	.35	3.29	4.71	2.00
	Occupational Therapy Assistant	4	4.75	1.89	.95	1.74	7.76	2.00
	Total	30	4.10	1.77	.32	3.44	4.76	2.00
Acceptance	Occupational Therapist	26	6.27	1.54	.30	5.65	6.89	2.00
	Occupational Therapy Assistant	4	5.75	1.71	.85	3.03	8.47	4.00
	Total	30	6.20	1.54	.28	5.62	6.78	2.00
Religion	Occupational Therapist	26	3.46	1.94	.38	2.68	4.25	2.00
	Occupational Therapy Assistant	4	6.00	.82	.41	4.70	7.30	5.00
	Total	30	3.80	2.02	.37	3.04	4.56	2.00
Self-blame	Occupational Therapist	26	3.27	1.28	.25	2.75	3.79	2.00
	Occupational Therapy Assistant	4	3.00	1.41	.71	.75	5.25	2.00
	Total	30	3.23	1.28	.23	2.76	3.71	2.00

Table 7

Descriptive Analysis of Brief COPE Results by Setting

	Setting	N	Mean	Std. Deviation	Std. Error	95% Confidence Interval for Mean		Minimum
						Lower Bound	Upper Bound	
Self-distraction	More than 2 settings	11	4.64	1.50	.45	3.63	5.65	3.00
	Outpatient	4	3.00	1.41	.71	.75	5.25	2.00
	Hospital	5	5.20	.84	.37	4.16	6.24	4.00
	Long-term Care/- Skilled Nursing Facility	3	4.67	1.15	.67	1.80	7.54	4.00
	Mental Health	1	6.00	NaN	NaN	NaN	NaN	6.00
	Schools	3	4.67	.58	.33	3.23	6.10	4.00
	Academia	3	5.67	.58	.33	4.23	7.10	5.00
	Total	30	4.67	1.35	.25	4.16	5.17	2.00
	Active coping	More than 2 settings	11	4.91	1.81	.55	3.69	6.13
Outpatient		4	5.25	2.75	1.38	.87	9.63	2.00
Hospital		5	4.60	2.07	.93	2.03	7.17	3.00
Long-term Care/- Skilled Nursing Facility		3	4.67	1.15	.67	1.80	7.54	4.00
Mental Health		1	7.00	NaN	NaN	NaN	NaN	7.00
Schools		3	4.33	.58	.33	2.90	5.77	4.00
Academia		3	6.00	1.00	.58	3.52	8.48	5.00
Total		30	5.00	1.74	.32	4.35	5.65	2.00
Denial		More than 2 settings	11	2.55	1.04	.31	1.85	3.24
	Outpatient	4	2.25	.50	.25	1.45	3.05	2.00
	Hospital	5	2.60	1.34	.60	.93	4.27	2.00
	Long-term Care/- Skilled Nursing Facility	3	2.00	.00	.00	2.00	2.00	2.00
	Mental Health	1	4.00	NaN	NaN	NaN	NaN	4.00
	Schools	3	2.67	.58	.33	1.23	4.10	2.00
	Academia	3	2.67	1.15	.67	-.20	5.54	2.00
	Total	30	2.53	.94	.17	2.18	2.88	2.00
	Substance use	More than 2 settings	11	2.18	.60	.18	1.78	2.59
Outpatient		4	2.00	.00	.00	2.00	2.00	2.00
Hospital		5	3.20	2.17	.97	.51	5.89	2.00
Long-term Care/- Skilled Nursing Facility		3	2.00	.00	.00	2.00	2.00	2.00
Mental Health		1	2.00	NaN	NaN	NaN	NaN	2.00
Schools		3	2.00	.00	.00	2.00	2.00	2.00

Setting	N	Mean	Std. Deviation	Std. Error	95% Confidence Interval for Mean		Minimum	
					Lower Bound	Upper Bound		
Academia	3	3.67	1.53	.88	-13	7.46	2.00	
Total	30	2.43	1.14	.21	2.01	2.86	2.00	
Use of emotional support	More than 2 settings	11	4.82	1.54	.46	3.79	5.85	2.00
	Outpatient	4	4.00	2.83	1.41	-.50	8.50	2.00
	Hospital	5	5.40	2.79	1.25	1.93	8.87	2.00
	Long-term Care/- Skilled Nursing Facility	3	5.00	1.00	.58	2.52	7.48	4.00
	Mental Health	1	5.00	NaN	NaN	NaN	NaN	5.00
	Schools	3	4.67	1.15	.67	1.80	7.54	4.00
	Academia	3	4.33	2.52	1.45	-1.92	10.58	2.00
	Total	30	4.77	1.87	.34	4.07	5.46	2.00
	Use of instrumental support	More than 2 settings	11	4.45	1.81	.55	3.24	5.67
Outpatient		4	3.50	2.38	1.19	-.29	7.29	2.00
Hospital		5	4.00	1.58	.71	2.04	5.96	2.00
Long-term Care/- Skilled Nursing Facility		3	5.00	1.00	.58	2.52	7.48	4.00
Mental Health		1	6.00	NaN	NaN	NaN	NaN	6.00
Schools		3	4.67	.58	.33	3.23	6.10	4.00
Academia		3	5.33	2.08	1.20	.16	10.50	3.00
Total		30	4.47	1.68	.31	3.84	5.09	2.00
Behavioral disengagement		More than 2 settings	11	2.45	.69	.21	1.99	2.92
	Outpatient	4	2.00	.00	.00	2.00	2.00	2.00
	Hospital	5	3.20	1.64	.73	1.16	5.24	2.00
	Long-term Care/- Skilled Nursing Facility	3	2.67	.58	.33	1.23	4.10	2.00
	Mental Health	1	2.00	NaN	NaN	NaN	NaN	2.00
	Schools	3	3.33	.58	.33	1.90	4.77	3.00
	Academia	3	3.67	2.89	1.67	-3.50	10.84	2.00
	Total	30	2.73	1.20	.22	2.28	3.18	2.00
	Venting	More than 2 settings	11	4.18	1.25	.38	3.34	5.02
Outpatient		4	3.00	1.15	.58	1.16	4.84	2.00
Hospital		5	4.20	1.92	.86	1.81	6.59	2.00
Long-term Care/- Skilled Nursing Facility		3	3.67	1.53	.88	-.13	7.46	2.00
Mental Health		1	4.00	NaN	NaN	NaN	NaN	4.00
Schools		3	5.33	.58	.33	3.90	6.77	5.00
Academia		3	3.00	1.73	1.00	-1.30	7.30	2.00
Total		30	3.97	1.43	.26	3.43	4.50	2.00
Positive reframing		More than 2 settings	11	5.36	1.80	.54	4.15	6.58

	Setting	N	Mean	Std. Deviation	Std. Error	95% Confidence Interval for Mean		Minimum
						Lower Bound	Upper Bound	
	Outpatient	4	4.50	3.00	1.50	-.27	9.27	2.00
	Hospital	5	4.80	2.39	1.07	1.84	7.76	2.00
	Long-term Care/- Skilled Nursing Facility	3	3.67	.58	.33	2.23	5.10	3.00
	Mental Health	1	7.00	NaN	NaN	NaN	NaN	7.00
	Schools	3	5.00	1.73	1.00	.70	9.30	4.00
	Academia	3	6.67	.58	.33	5.23	8.10	6.00
	Total	30	5.13	1.94	.35	4.41	5.86	2.00
Planning	More than 2 settings	11	5.00	1.73	.52	3.84	6.16	2.00
	Outpatient	4	5.00	2.58	1.29	.89	9.11	2.00
	Hospital	5	5.00	1.87	.84	2.68	7.32	2.00
	Long-term Care/- Skilled Nursing Facility	3	4.33	.58	.33	2.90	5.77	4.00
	Mental Health	1	8.00	NaN	NaN	NaN	NaN	8.00
	Schools	3	5.67	.58	.33	4.23	7.10	5.00
	Academia	3	4.67	2.52	1.45	-1.58	10.92	2.00
	Total	30	5.07	1.76	.32	4.41	5.72	2.00
Humor	More than 2 settings	11	4.09	1.81	.55	2.87	5.31	2.00
	Outpatient	4	3.00	2.00	1.00	-.18	6.18	2.00
	Hospital	5	4.20	1.79	.80	1.98	6.42	2.00
	Long-term Care/- Skilled Nursing Facility	3	4.67	.58	.33	3.23	6.10	4.00
	Mental Health	1	3.00	NaN	NaN	NaN	NaN	3.00
	Schools	3	6.33	.58	.33	4.90	7.77	6.00
	Academia	3	3.00	1.73	1.00	-1.30	7.30	2.00
	Total	30	4.10	1.77	.32	3.44	4.76	2.00
Acceptance	More than 2 settings	11	6.00	1.34	.40	5.10	6.90	4.00
	Outpatient	4	5.25	2.50	1.25	1.27	9.23	2.00
	Hospital	5	5.80	1.10	.49	4.44	7.16	4.00
	Long-term Care/- Skilled Nursing Facility	3	6.67	2.31	1.33	.93	12.40	4.00
	Mental Health	1	8.00	NaN	NaN	NaN	NaN	8.00
	Schools	3	6.33	.58	.33	4.90	7.77	6.00
	Academia	3	7.67	.58	.33	6.23	9.10	7.00
	Total	30	6.20	1.54	.28	5.62	6.78	2.00
Religion	More than 2 settings	11	3.45	2.16	.65	2.00	4.91	2.00
	Outpatient	4	3.00	2.00	1.00	-.18	6.18	2.00
	Hospital	5	3.60	1.14	.51	2.18	5.02	2.00

Setting	N	Mean	Std. Deviation	Std. Error	95% Confidence Interval for Mean		Minimum
					Lower Bound	Upper Bound	
Long-term Care/- Skilled Nursing Facility	3	5.67	3.21	1.86	-2.32	13.65	2.00
Mental Health	1	7.00	NaN	NaN	NaN	NaN	7.00
Schools	3	3.67	.58	.33	2.23	5.10	3.00
Academia	3	3.67	2.08	1.20	-1.50	8.84	2.00
Total	30	3.80	2.02	.37	3.04	4.56	2.00
Self-blame							
More than 2 settings	11	3.45	1.21	.37	2.64	4.27	2.00
Outpatient	4	2.00	.00	.00	2.00	2.00	2.00
Hospital	5	3.20	1.30	.58	1.58	4.82	2.00
Long-term Care/- Skilled Nursing Facility	3	3.00	1.00	.58	.52	5.48	2.00
Mental Health	1	3.00	NaN	NaN	NaN	NaN	3.00
Schools	3	4.67	1.53	.88	.87	8.46	3.00
Academia	3	3.00	1.73	1.00	-1.30	7.30	2.00
Total	30	3.23	1.28	.23	2.76	3.71	2.00

Table 8

Difficulties Faced by Occupational Therapy Practitioners During the COVID-19 Pandemic Analyzed by Dedoose Software

Difficulties Faced During COVID-19 Pandemic	Count
Reduced income	3
Staff shortages	6
No difficulties	3
Change in workflow	8
Work apathy	3
Increase workload	4
Worried about spreading COVID-19 to others	8
Limited facility support	5
Poor work conditions	2
Restlessness	3
Lack of community support	4
Burnout	5
Work-life balance	2

Table 9

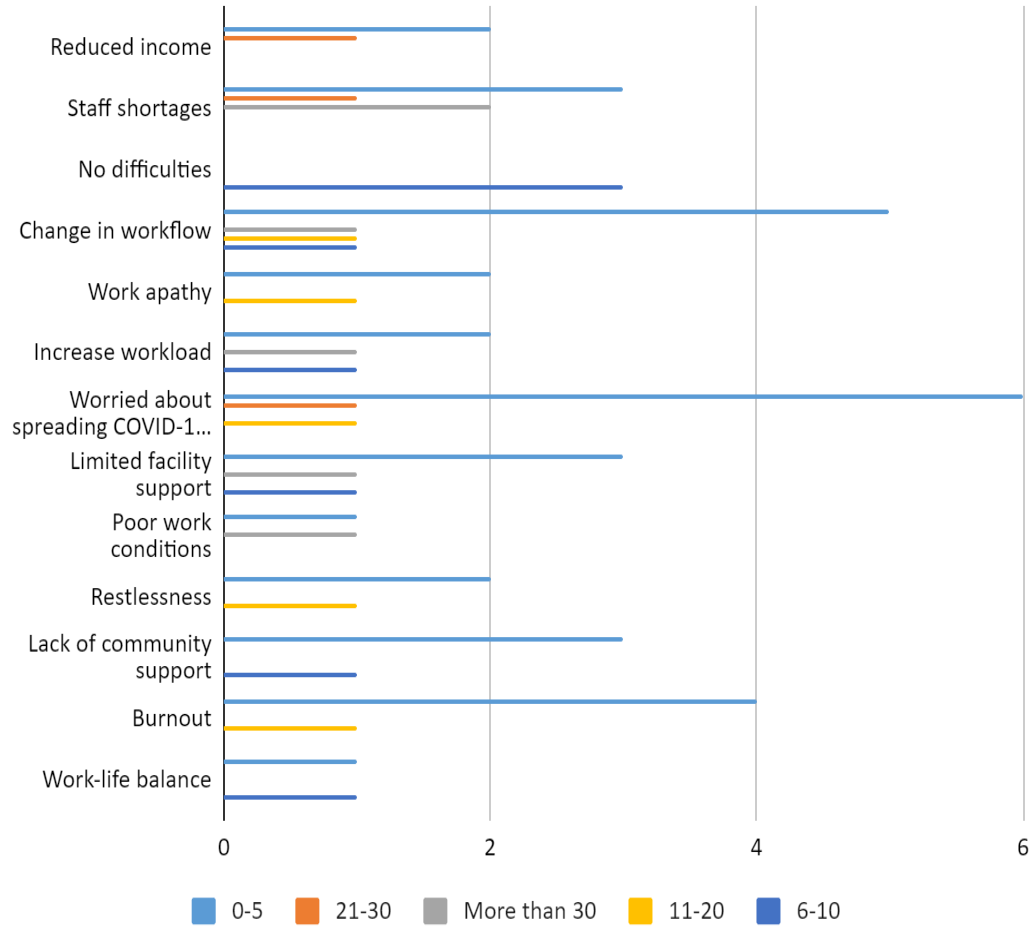
Coping Skills Used by Occupational Therapy Practitioners During the COVID-19 Pandemic Analyzed by Dedoose Software

Coping Skills Used During COVID-19 Pandemic	Count
Interacting with coworkers/staff	5
Exercise	6
Adapt to environment and work	3
Relaxing	4
Time management	2
No difficulties	3
Interacting with friends/family	6
Keeping COVID precautions	4
Finding Distractions	2
Therapy	2
Acceptance	6
Praying	2

Figure 1

Common Themes From Open-ended Questions by Experience

Difficulties Faced During the Pandemic by Years of Experience



Coping Skills Used During the Pandemic by Years of Experience

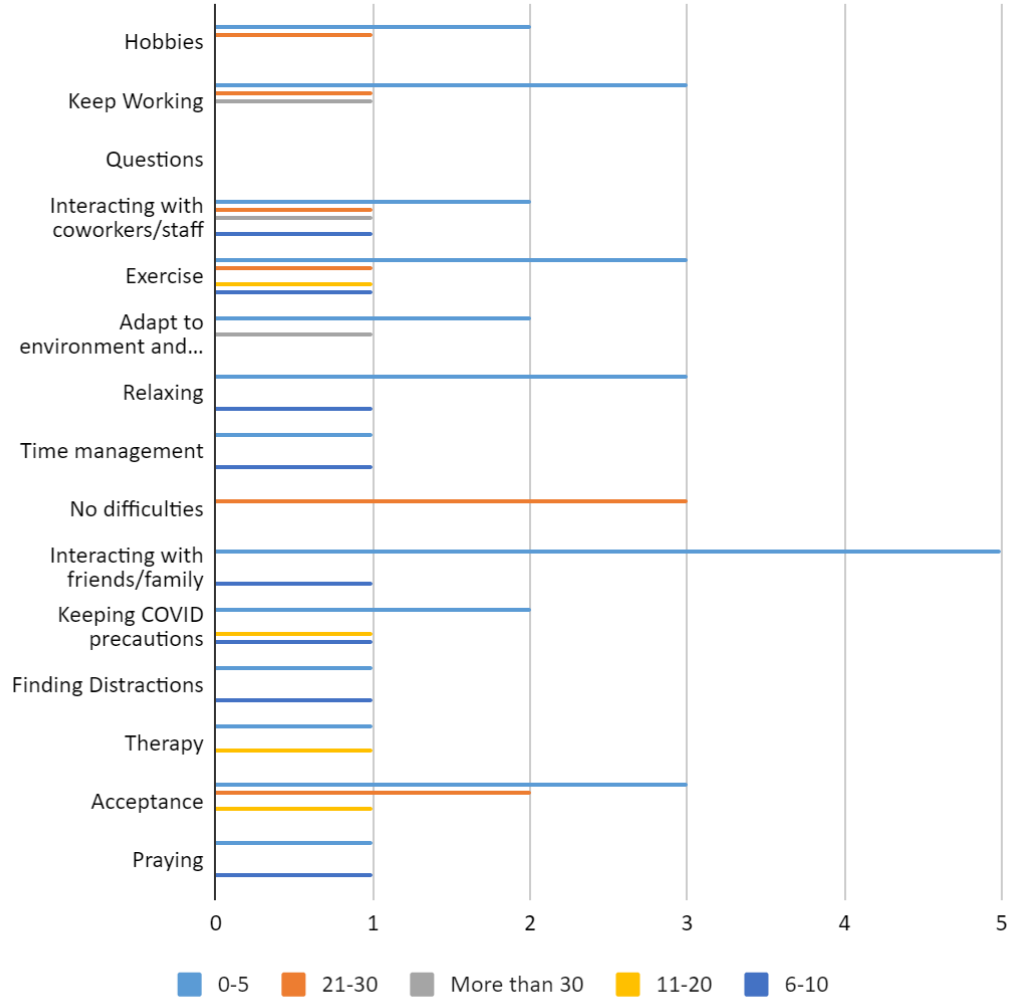
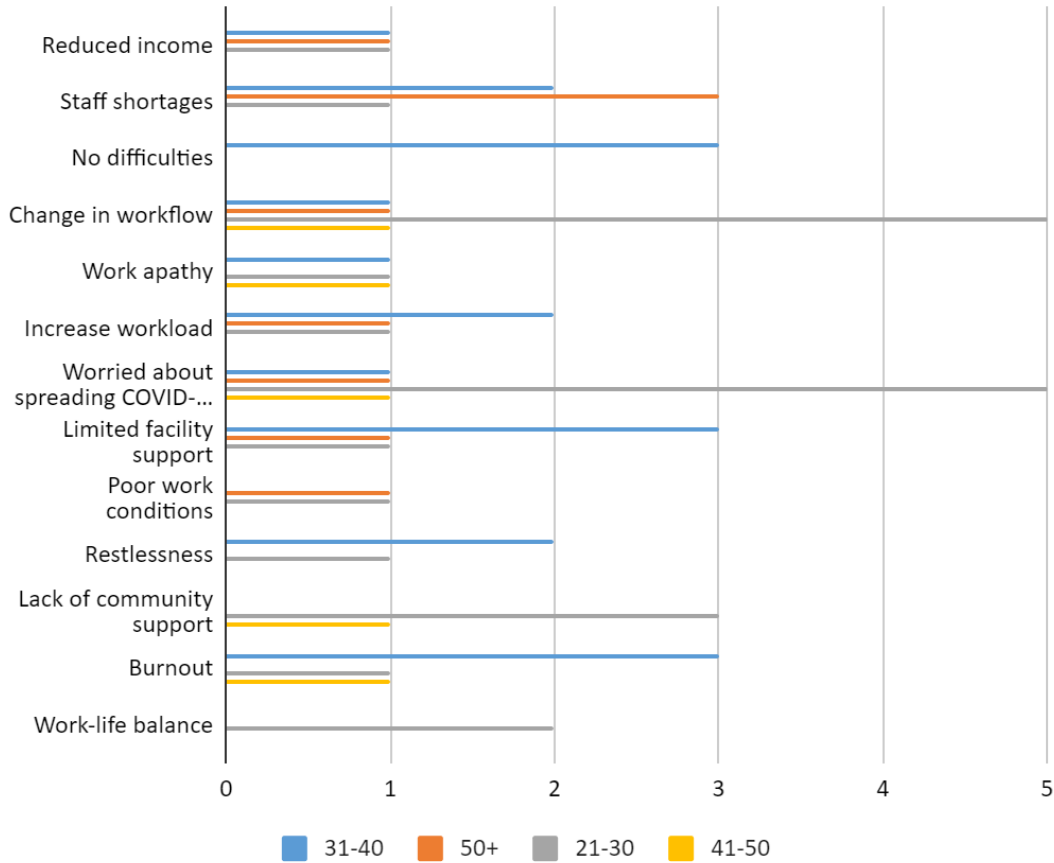


Figure 2

Common Themes From Open-ended Questions by Age

Difficulties Faced During the Pandemic by Age



Coping Skills Used During the Pandemic by Age

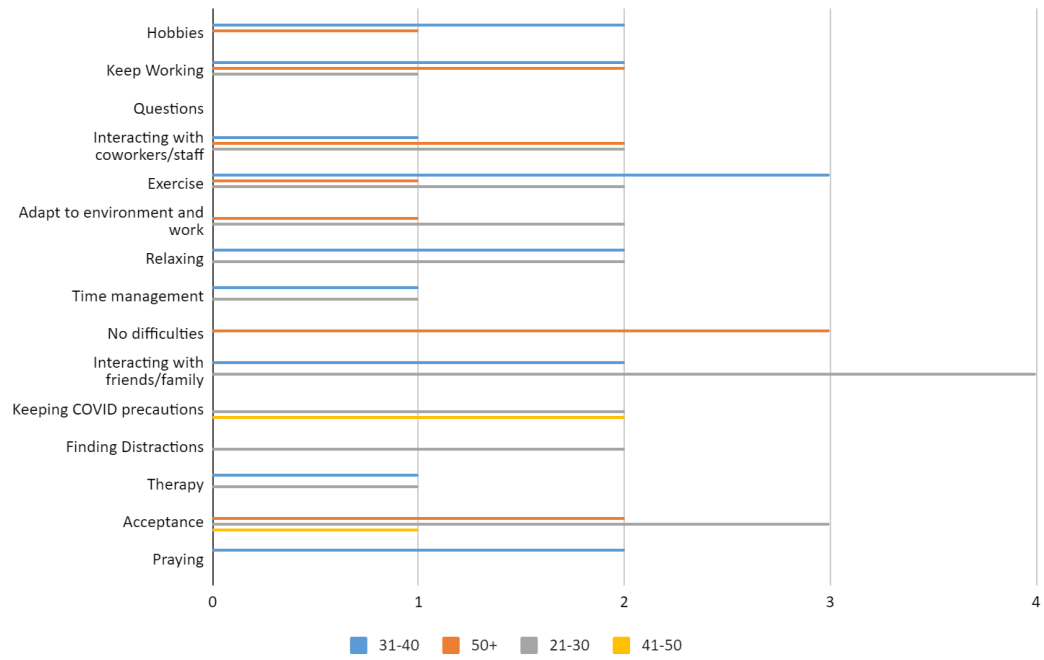
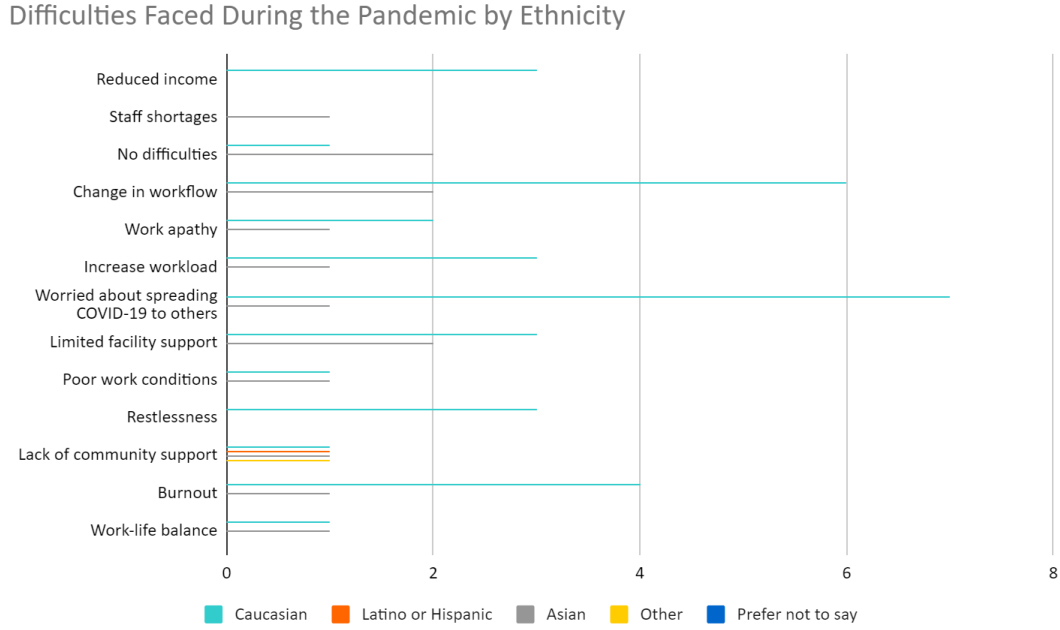


Figure 3

Common Themes From Open-ended Questions by Ethnicity



Coping Skills Used During the Pandemic by Ethnicity

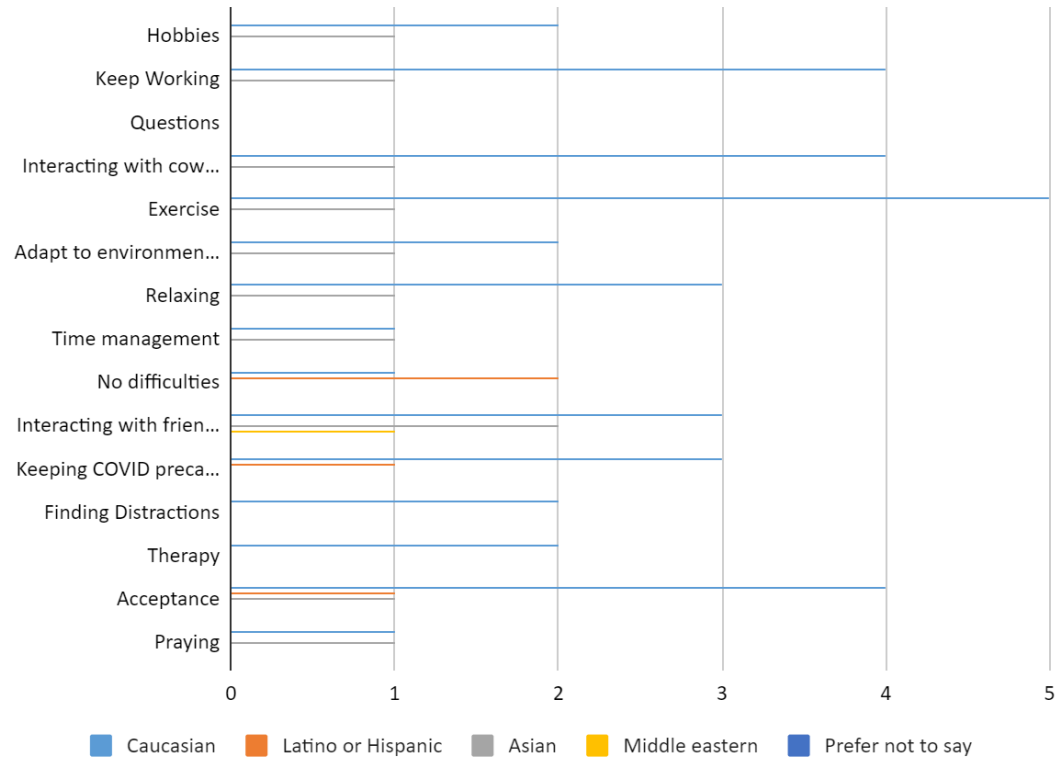
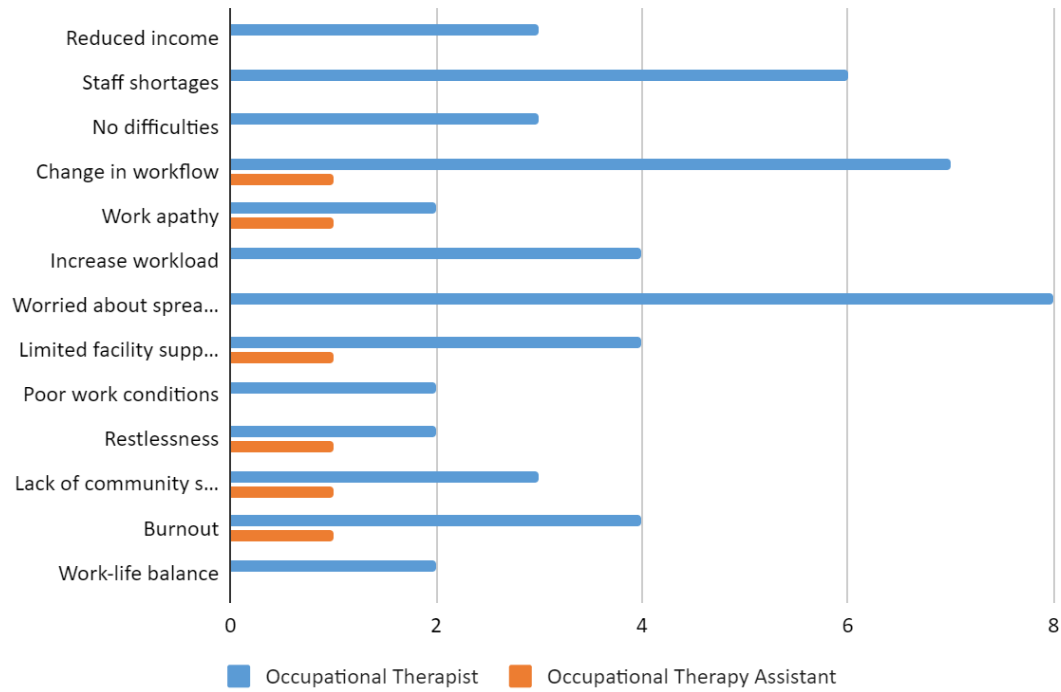


Figure 4

Common Themes From Open-ended Questions by Type of Practitioner

Difficulties Faced During the Pandemic by Type of Practitioner



Coping Skills Used During the Pandemic by Type of Practitioner

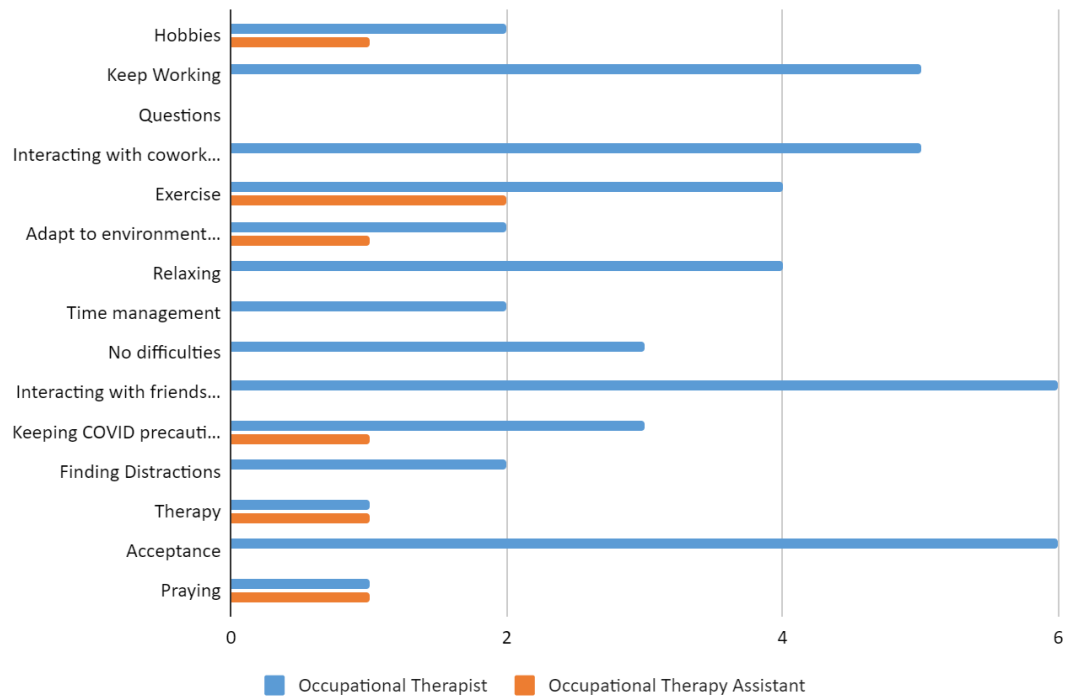
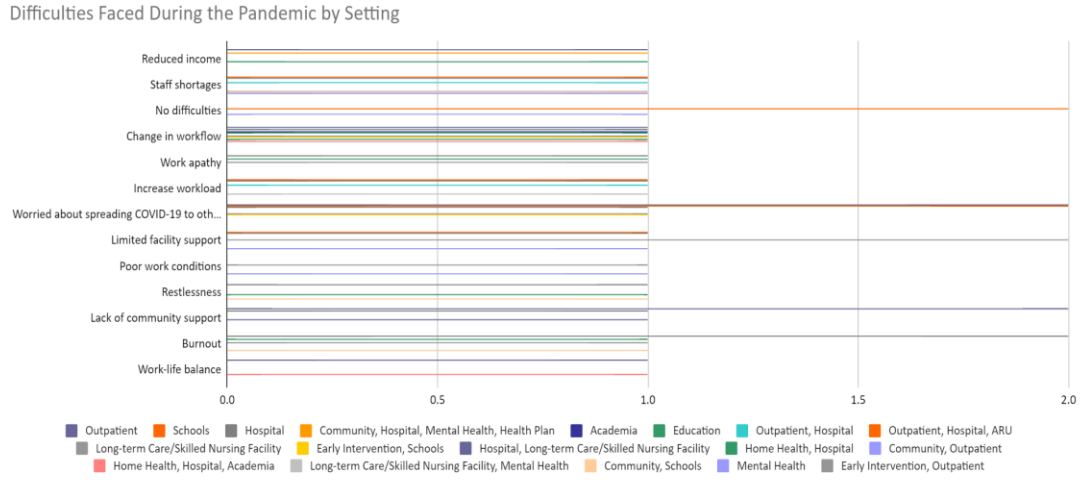
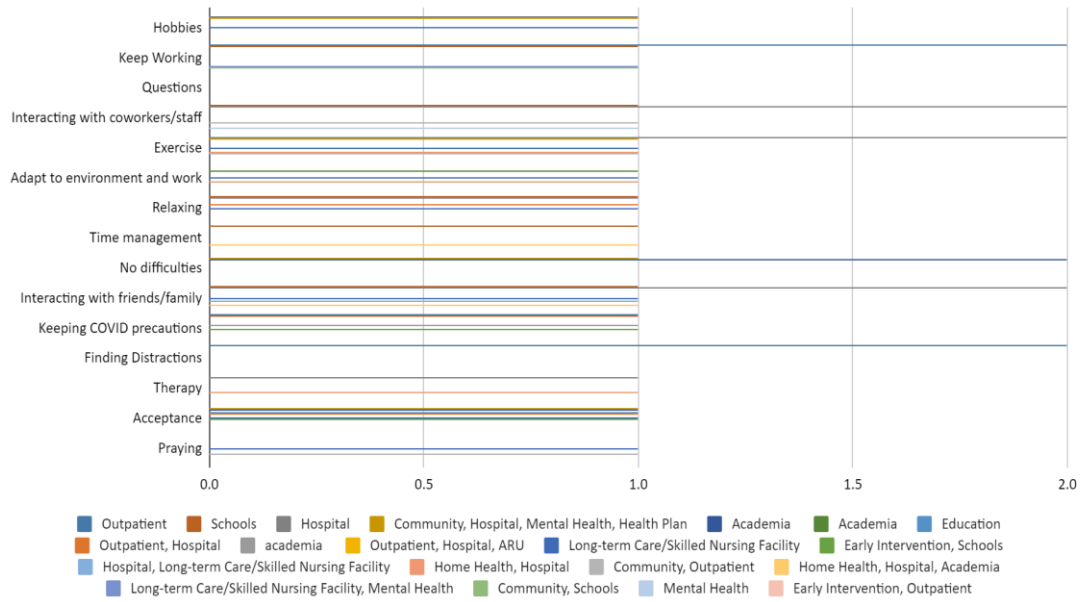


Figure 5

Common Themes From Open-ended Questions by Setting



Coping Skills Used During the Pandemic by Setting



Appendix A

Recruitment Flyer

COPING DURING THE PANDEMIC

Stanbridge University Institutional Review Board Approved



CALLING ALL OT PRACTITIONERS (OT/OTA)



How are you coping during the pandemic?

Stanbridge University MSOT students want to know how OT practitioners (OTs/COTAs) are coping while working throughout the pandemic. Please consider answering our **5-10 minute** survey to help with our thesis project!



<https://forms.gle/jWJUQmH7vxydD7xy5>

For any questions contact Maegan Mangilog at maegan.mangilog@my.stanbridge.edu or Frances Gee at fgee@stanbridge.edu

Appendix B

Coping Survey

The Occupational Therapy Practitioner: Coping Skills During the COVID-19 Pandemic

* Required

Basic Information

How many years have you been working as an Occupational Therapy Practitioner? *

- 0-5
- 6-10
- 11-20
- 21-30
- More than 30

What is your age? *

- Under 20
- 21-30
- 31-40
- 41-50
- 50+

What is your ethnicity?

- Caucasian
- African-American
- Latino or Hispanic
- Asian
- Native-American
- Pacific Islander
- Prefer not to say
- Other: _____

Are you an Occupational Therapist or Occupational Therapy Assistant? *

- Occupational Therapist
- Occupational Therapy Assistant

What type of setting(s) do you currently work in ? Choose all that apply. *

- Community
- Early Intervention
- Outpatient
- Home Health
- Hospital
- Long-term Care/Skilled Nursing Facility
- Mental Health
- Schools
- Other: _____

Brief Coping Orientation to Problems Experienced (Brief-COPE)

Each item says something about a particular way of coping. We want to know to what extent you've been doing what the item says. How much or how frequently. Don't answer on the basis of whether it seems to be working or not—just whether or not you're doing it. Use these response choices. Try to rate each item separately in your mind from the others. Make your answers as true FOR YOU as you can.

Answer the following questions: *

	1. I haven't been doing this at all	2. I've been doing this a little bit	3. I've been doing this a medium amount	4. I've been doing this a lot
1. I've been turning to work or other activities to take my mind off things.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
2. I've been concentrating my efforts on doing something about the situation I'm in.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
3. I've been saying to myself "this isn't real."	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
4. I've been using alcohol or other drugs to make myself feel better.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

5. I've been getting emotional support from others.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
6. I've been giving up trying to deal with it.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
7. I've been taking action to try to make the situation better.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
8. I've been refusing to believe that it has happened.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
9. I've been saying things to let my unpleasant feelings escape.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
10. I've been getting help and advice from other people.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
11. I've been using alcohol or other drugs to help me get through it.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
12. I've been trying to see it in a different light, to make it seem more positive.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
13. I've been criticizing myself.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
14. I've been trying to come up with a strategy about what to do.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
15. I've been getting comfort and understanding from someone.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
16. I've been giving up the attempt to cope.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
17. I've been looking for something good in what is happening.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
18. I've been making jokes about it.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

19. I've been doing something to think about it less, such as going to movies,	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
20. I've been accepting the reality of the fact that it has happened.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
21. I've been expressing my negative feelings.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
22. I've been trying to find comfort in my religion or spiritual beliefs.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
23. I've been trying to get advice or help from other people about what to do.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
24. I've been learning to live with it.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
25. I've been thinking hard about what steps to take.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
26. I've been blaming myself for things that happened.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
27. I've been praying or meditating.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
28. I've been making fun of the situation.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Coping Skills

In 1-3 sentences, describe any difficulties you currently face at work and at home due to COVID-19.

Your answer

In 1-3 sentences, describe the coping skills you currently use when faced with the above difficulties.

Your answer

Submit

Clear form

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Google Forms

Appendix C

Consent Form

The Occupational Therapy Practitioner: Coping Skills During the COVID-19 Pandemic

* Required

Consent to Participate in Research Stanbridge University

Tommy Vu, Maegan Mangilog, Neil Kim, and Dennis Lam, graduate students in the Master of Occupational Therapy Program at Stanbridge University, are conducting a research study to look at how occupational therapy practitioners coped during the COVID-19 pandemic. You are being asked to complete this survey because of your first-hand experience working during the pandemic.

Participation is voluntary. The survey will take approximately 5-10 minutes to complete. You must be 18 years or older to complete this survey.

There are no foreseeable serious risks involved in this study. Please try to answer all questions. However, please skip any questions that make you feel uncomfortable. Your responses are anonymous.

Please feel free to contact Maegan Mangilog or her Principal Investigator if you have any questions or concerns:

Maegan Mangilog

maegan.mangilog@my.stanbridge.edu

Frances Gee

fgee@standbridge.edu

If you have questions about your rights as a research participant, you may contact the Stanbridge University Institutional Review Board (IRB), which is concerned with the protection of volunteers in research projects. Please call IRB Office at 949-794-9090 or via email at irb@stanbridge.edu.

If you would prefer not to participate, please do not fill out a survey.

If you consent to participate, please complete the survey.

Clicking the box below indicates I have read the above Consent Form and agree *
to participate in the study.

I agree

Next

Clear form

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Appendix D

IRB Approval

Dear Dr. Frances Gee and Students,

The Stanbridge University Institutional Review Board has completed the review of your application entitled "The Occupational Therapy Practitioner: Coping Skills During the COVID-19 Pandemic." Your application (MSOT011-507) is approved and categorized as Exempt.

IRB Application Number	MSOT011-507
Date	08/09/2022
Level of Review	Exempt
Application Approved	X
Conditional Approval	
Disapproved	
Comments	The requested Minor changes have been reviewed and confirmed as completed by the IRB. (08/09/2022)
Signature of IRB Chair	

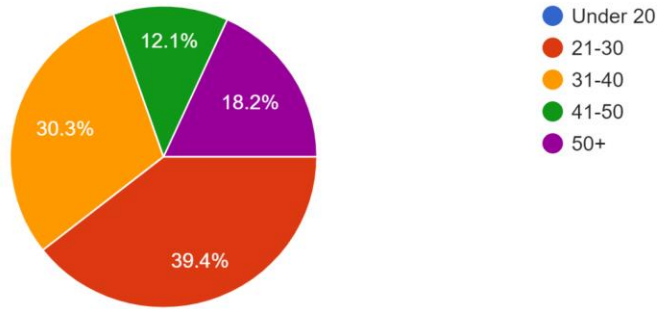
Please note that any anticipated changes to this approved protocol requires submission of an IRB Modification application with IRB approval confirmed prior to their implementation.

Sincerely,
 Julie Grace, M.S., M.A.
 IRB Chair

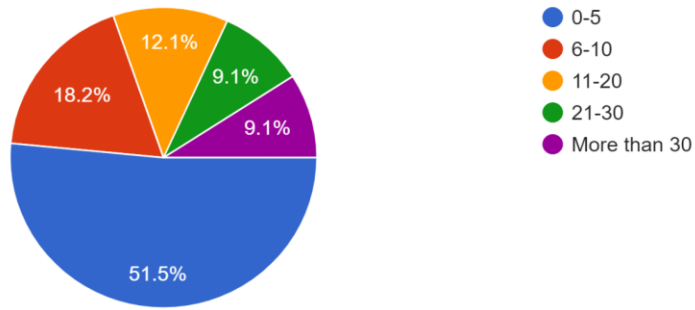
Appendix E

Demographic Graphs

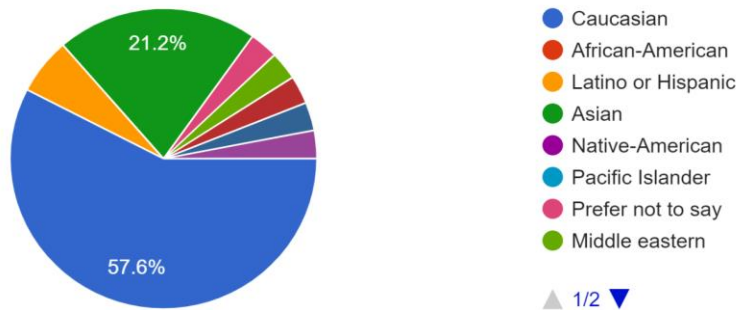
What is your age?
33 responses



How many years have you been working as an Occupational Therapy Practitioner?
33 responses

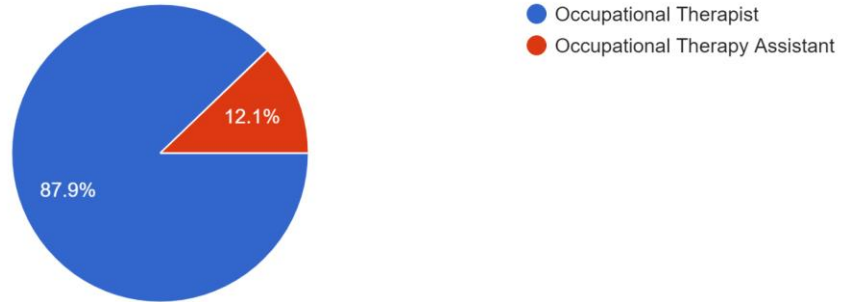


What is your ethnicity?
33 responses



Are you an Occupational Therapist or Occupational Therapy Assistant?

33 responses



What type of setting(s) do you currently work in ? Choose all that apply.

33 responses

