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Original Article

Analysis from an occupational perspective of the telehealth use in occupational therapy in times of confinement

Análise sob a perspectiva ocupacional do uso da telesaúde na terapia ocupacional em tempos de confinamento

Análisis desde una perspectiva ocupacional al uso de la telesalud en terapia ocupacional en tiempos de confinamiento

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Abstract

Introduction: The actions adopted with the purpose of avoiding community infections, during the COVID-19 pandemic, meant an occupational interruption since these measures prevented or restricted the participation in significant occupations of people. At the same time, the different health institutions and health professionals had to resort to telehealth to provide continuity of care. **Objective:** To analyze from an occupational perspective the use of telehealth in Occupational Therapy in confinement contexts. **Methodology:** Qualitative. Information is produced through focus groups and individual interviews. 9 students, 10 teachers, 5 users and/or family members and 5 members of the care teams participate in this study. An analysis of the thematic content is carried out through the triangulation of actors to integrate the opinions of all the participants, later in order to deepen the use of telehealth from an occupational perspective, theoretical triangulation is included. **Results:** Telehealth as an occupation materializes the possibility of having socio-emotional support and allows collaboration in search of well-being in times of social isolation. It is also an occupation that allowed recognizing the home as a territory, in which the appropriation of material and relational resources occurs in a collaborative way between the treatment team and the users. **Conclusions:** Telehealth is a collective occupation that allows re-existence in times of occupational interruption and new forms of occupational dislocation.

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Keywords: Remote Consultation, Occupational Therapy, Activities of Daily Living, Territory.

Resumo

Introdução: As ações adotadas com o objetivo de evitar infecções comunitárias, durante a pandemia de COVID-19, significaram uma interrupção ocupacional, uma vez que essas medidas impediram ou restringiram a participação em ocupações significativas de pessoas. Ao mesmo tempo, as diferentes instituições de saúde e profissionais de saúde tiveram que recorrer à telessaúde para dar continuidade aos cuidados. **Objetivo:** Analisar numa perspetiva ocupacional a utilização da telessaúde em Terapia Ocupacional em contextos de confinamento. **Metodologia:** Qualitativa. A informação é produzida através de grupos focais e entrevistas individuais. Participaram deste estudo 9 alunos, 10 professores, 5 usuários e/ou familiares e 5 integrantes das equipes assistenciais. É realizada uma análise do conteúdo temático através da triangulação de atores para integrar as opiniões de todos os participantes, posteriormente para aprofundar o uso da telessaúde do ponto de vista ocupacional, inclui-se a triangulação teórica. **Resultados:** A telessaúde como ocupação materializa a possibilidade de ter suporte socioemocional e permite a colaboração na busca do bem-estar em tempos de isolamento social. É também uma ocupação que permitiu reconhecer a casa como um território, no qual a apropriação de recursos materiais e relacionais ocorre de forma colaborativa entre a equipe de tratamento e os usuários. **Conclusões:** A telessaúde é uma ocupação coletiva que permite a reexistência em tempos de interrupção ocupacional e novas formas de deslocamento ocupacional.

Palavras-chave: Consulta Remota, Terapia Ocupacional, Atividades Cotidianas, Território.

Resumen

Introducción: Las acciones adoptadas con el propósito de evitar los contagios comunitarios, durante la pandemia por COVID-19, significó una interrupción ocupacional ya que estas medidas impidieron o restringieron la participación en ocupaciones significativas de las personas. Al mismo tiempo, las distintas instituciones sanitarias y los profesionales del área de la salud tuvieron que acudir a la telesalud para dar continuidad a la atención y cuidados. **Objetivo:** Analizar desde una perspectiva ocupacional el uso de la telesalud en Terapia Ocupacional en contextos de confinamiento. **Metodología:** De tipo cualitativa. La información se produce a través de grupos de discusión y entrevistas individuales. Participaron de este estudio 9 estudiantes, 10 docentes, 5 usuarios/as y/o familiares y 5 integrantes de los equipos de atención. Se realizó un análisis del contenido temático a través de la triangulación de actores para integrar las opiniones de todos/as los/as participantes, posteriormente con el fin de profundizar desde una perspectiva ocupacional el uso de la telesalud se incluye la triangulación teórica. **Resultados:** La telesalud como ocupación materializa la posibilidad de contar con apoyo socioemocional y permite la colaboración en busca del bienestar en tiempos de aislamiento social. También es una ocupación que permitió reconocer el hogar como un territorio, en el que se produce la apropiación de recursos materiales y relacionales de una manera colaborativa entre el equipo tratante y los/as usuarios/as. **Conclusiones:** La telesalud es una ocupación colectiva que permite la re-existencia

en tiempos de interrupción ocupacional y de nuevas formas de dislocación ocupacional.

Palabras clave: Consulta Remota, Terapia Ocupacional, Actividades Cotidianas, Territorio.

Introduction

The pandemic revealed important problems for the population, such as job insecurity, decreased income and increased unemployment (Julián Vejar, 2020). In the case of Chile, the health crisis was intertwined with a deep sociopolitical crisis that demands structural changes and the overcoming of the neoliberal model, which is characterized by being extremely austere with social policies, denying the possibility of the State having a system of adequate protection to support citizens in times of crisis (Vidal, 2021), which is expressed in a public health system with great difficulties in facing the crisis, as a result of abandonment and systematic defunding.

On the other hand, according to the opinion of Santos (2020) and Parada-Lezcano et al. (2022) the economic support measures for citizens were focused, late and insufficient, aimed at protecting big capital and the macroeconomics to the detriment of the vulnerable population. Regarding the poor state support, Escobar (2020) and Anigstein et al. (2021) point out that the citizens, through community self-organization, were able to cope with life and cover some basic needs such as food through the common pot in the poorest and most needy sectors.

From an occupational point of view, the actions adopted with the purpose of avoiding community infections by COVID-19 meant an occupational interruption, since these measures prevented or restricted participation in significant and necessary occupations such as social, community, recreational, leisure and free time, work and educational, in the places that were usually used for this (Whiteford et al., 2020; Carlsson et al., 2022; Richardson et al., 2022). These measures forced people to carry out almost all occupations at home, such as work, education and health care, which went beyond the daily lives of people and their families.

In the opinion of Asbjørnslett et al. (2023), occupational interruption is a transitory phenomenon that can cause alterations in people's identity and occupational balance. For their part, Nizzero et al. (2017) affirm that occupational interruption entails difficulties in the social and emotional dimensions of people, as well as in the being, doing and belonging of the occupations they carry out. At the same time, these authors invite us to think about the importance of the meanings that people attribute to the occupations they carry out during periods of occupational interruption, since it would be an important aspect to resist the adverse effects on health and well-being of this phenomenon.

Telehealth in occupational therapy

The situation of mandatory confinement or lockdown during the COVID-19 pandemic, mainly during the years 2020-2021, caused the different health institutions

in the world and health professionals to have to resort to telehealth to provide continuity of care and health care and allow the exercise of the right to health since it safeguards quality (Chile, 2018). Occupational therapy was not the exception and had to adapt to the use of telehealth to offer care to the population. Several professional associations at the international and national level developed guidelines and recommendations that guided the appropriate development of this strategy (Colegio de Terapeutas Ocupacionales de Chile, 2020; Sy et al., 2020; Asociación Argentina de Terapistas Ocupacionales, 2020).

Telehealth in occupational therapy offers positive therapeutic results for the care of people with different health problems (Hung Kn & Fong, 2019; Priyadharsini & Chiang, 2020; Ricci et al., 2021), especially in countries that have the appropriate training for its implementation (Hoel et al., 2021). For their part, several authors affirm that telehealth improves access to occupational therapy interventions and that it presents a high level of satisfaction by the users who receive it (Mihevc et al., 2022; Breeden et al. 2023; Knapp et al., 2023).

Some occupational therapists affirm that telehealth could be a substitute for in-person care, while others estimate that after the COVID 19 pandemic it will be established as a legitimate option for the delivery of benefits (Dahl-Popolizio et al. 2020). In this same line of argument, Larsson-Lund & Nyman (2020) invite occupational therapists to include virtualization in their work, given that it can offer people experiences of greater occupational commitment in increasingly digitalized societies, without ignoring that an important group of the population is excluded from this possibility.

Based on the arguments just raised, in occupational therapy, telehealth should be understood not only as a virtual intervention strategy, but we should also be able to understand that the participation in it is a complex occupation and must be studied under that proposition (Pereira, 2020). It is considered that to move forward in this purpose it is necessary, as pointed out by Njelesani et al. (2014), to include an occupational perspective in this analysis, that is, being able to observe and reflect on human activity in different socio-historical moments, understanding that this activity corresponds to human occupation as such. Based on what Farías (2022) suggests, this exercise also involves identifying the articulations between the social-individual and the everyday-social at the time of carrying out occupations, as is the case of participating in telehealth, especially in contexts of confinement and social isolation.

Considering that human occupation is being and doing in the field of intersubjectivity that configures it socially (Guajardo, 2014), that it is a relational and situated phenomenon that is expressed and identified in the singularities that speak, feel and live in a certain time-place (Valderrama & Lara, 2013); which is the way in which people give meaning to their daily lives and which constitutes them as occupational beings (Silva Araújo et al., 2011); it is considered that the most appropriate approach to understand telehealth from an occupational perspective is through the reflection of its protagonists. It is essential to deepen our knowledge about it, to collect the meanings given to it by those who experience it at some moment in their lives, especially in conditions of occupational interruption resulting from the COVID-19 pandemic, a condition in which this study is part.

Context and objective of the study

This study aims to analyze from an occupational perspective the use of telehealth in occupational therapy in contexts of confinement and social-health crisis. To fulfill this purpose, a care experience developed jointly between the occupational therapy career of a private University and a public Hospital in the city of Concepción in Chile is used, specifically in 5 care units. This initiative is part of the recommendations to coordinate the public and private sectors to promote the use of telehealth (Portilla, 2013). This project was carried out between the months of June 2020 to July 2022, a period characterized in Chile by a series of restrictive measures on people's mobility, which meant many difficulties in receiving in-person care.

The project was organized as follows: the University had 1 professional occupational therapist guide teacher and 2 students in the internship (last year of training), who provided care through telehealth to the referred users by the treating team of the respective unit.

This team carried out the following therapeutic actions: evaluation and training of basic and domestic activities of daily living (ADLs), restructuring of habits, sensory stimulation in children, training of transitions and transfers, development of educational material, among others. The care was carried out 1 or 2 per week for a total of 8 to 9 weeks. They lasted about 45 to 60 minutes each. Asynchronous communication between the occupational therapy team and the users was done through WhatsApp and email.

The treating team selects and refers users who require occupational therapy, considering access to connectivity and technology, as well as declaring a commitment to participate in care. At the same time, it offers a space for coordination and information for users for adequate continuity of care. These belong to different age ranges and have various health problems.

Methodology

This research is qualitative with a social-constructionist approach, since the meaning that the participants give to the lived experience is constructed jointly through language and the exchange of opinions (Di Silvestre, 2012).

Participants and information production techniques

The information is collected from 4 key participants: treatment teams, users and/or family members, students and teachers. The inclusion criteria for the *team members* were the following: professional who participates in the referral flow chart to occupational therapy for telehealth care, and who monitors the users who receive this care. In the case of *the users*, the inclusion criteria for the call were voluntariness, having the connectivity conditions for a virtual interview and being over 18 years old, in the case of the assisted girls, their family members and/or caregivers participated.

In the case of *students and teachers*, the inclusion criteria were voluntariness, having carried out or guided a professional telehealth practice on the devices included in the studied experience.

The research team summoned the participants via email, obtained from the coordination of the care units in the case of team members and users; and with the coordination of clinical fields of the career, in the case of students and teachers. Once those invited responded by explaining their interest in being part of the study, a telephone contact was made to explain the research and the ethical aspects involved, and then agree on the respective virtual meetings.

In the case of the team members and the users or family members, 10 individual qualitative interviews were carried out, since the aim was to reconstruct the experience in a framework of greater intimacy (Marradi et al., 2018). The interviews lasted 45 to 60 minutes.

In the case of students and teachers, the production of information was carried out through 4 focus groups, 2 with teachers and 2 with students, since these allow the construction of a shared meaning (Silveira et al., 2015). This technique is chosen because the experience analysed shares common aspects for the participants, such as the fact that telehealth was used for the first time as an intervention method, and other differentiating aspects, such as the fact that it was used to address different health problems, which offers an appropriate balance between homogeneity and heterogeneity (Beltrán, 2015). The duration of these meetings was between 60 and 90 minutes.

For all the mentioned techniques, a thematic script was developed from the analysis categories that was validated by expert triangulation. The main categories were: facilitators and obstacles of the experience, role of families, intervention strategies developed and benefits of telehealth. The interviews and focus groups were carried out virtually, through zoom, teams and/or meet platforms.

In total, 9 students, 10 teachers, 5 team members and 5 family members and/or users participated in this study. All the care units mentioned above are represented.

Table 1 presents a summary of the techniques implemented by each group participating in the study, as well as the device involved.

Table 1. Number of participants per referral device to occupational therapy and applied information production technique.

Referral Device	Focus group		Individual interviews	
	Students	Teachers	Team members	Users / Family members
Adult physical rehabilitation unit	2	2	1	2
Psychosocial Rehabilitation Center	2	1	1	1
Child Psychiatry and Mental Health Unit	2	2	1	2
Community Mental Health Center	1	2	1	-
Adult Mental Health Day Hospital	2	1	1	-
TOTAL	9	10	5	5

Source: Own elaboration.

From the above data, it is important to highlight that the absence of users and/or family members of the Community Mental Health Center and Adult Mental Health Day Hospital devices shows that the majority of people treated in these units had difficulties in accessing technology (devices and connectivity). In addition to the above,

they are centers with a small population under control, which decreased the probability of their participation in the call made.

Analysis plan

Based on what Campos & Turato (2009) suggested, thematic content analysis was carried out through the following strategy: the information produced was recorded, transcribed verbatim, and read several times to identify the most prominent and recurring aspects. The textual fragments were coded and categorized into a single mesh, comparing and integrating the stories of each participating group through the triangulation of actors. Subsequently, to establish the emerging themes of the analysis process, relationships between categories were sought by examining the contextual relevance of the stories. 2 themes, 6 categories and 14 subcategories were obtained. A summary of the results of this procedure is presented below in Table 2.

Table 2. Topics, categories and produced subcategories.

Topics	Categories	Subcategories
The home as an x-ray of reality in a pandemic	Conditions of the domestic space, intimacy and telehealth	Home privacy
		Home infraestructure
		Telehealth as a priority
	Materials, daily life and telehealth	Self-management
		Materials delivery
		Homemade materials
	Confined families and telehealth	Obstacles
		Facilitators
		Facilitators and obstacles
		Co-therapists
	Benefits of telehealth	Emotional support
		Progression in the ADLs
Telehealth, occupation and territory	In-person care	Preference for In-person care
	Home	Other territories

Source: Own elaboration.

Finally, in order to deepen the use of telehealth in times of confinement from an occupational perspective, theoretical triangulation is included (Piñero & Perozo, 2021).

Ethical considerations

This study has the approval of the scientific ethical committee of the Talcahuano Health Service, through evaluation document No. 13 of 2020, formalized in ordinary document No. 939, and through reapproval evaluation document No. 32 of year 2022. All participants approved an informed consent. In order to protect anonymity, the names of the institutions involved or the study participants are not included in this manuscript.

Results

To deliver the results, the texts are coded as follows: DG to refer to the discussion group held, T and S to refer to the teachers and students respectively. Each of them with a correlative number assigned to each participant and the focus group carried out respectively. In the case of the team members, TM and the assigned correlative number were used; lastly, in the case of users and/or caregivers, UE and the correlative number were used.

The home as an x-ray of reality in a pandemic

This topic deals with the infrastructure conditions and family dynamics observed in the home during the intervention process.

In some users' homes, the lack of privacy is presented as an obstacle to telehealth, since it can expose personal and intimate situations that should not be heard or involve third parties during the therapeutic process:

> […] *the issue of privacy, ... I remember that in an initial interview, part of the interview was whether the child was wanted or not and the child was nearby* (I8).

Other aspects considered as obstacles that do not allow adequate telehealth care are the architectural aspects and the lack of spaces in the users' homes:

> […] *here are users who cannot be treated by telehealth, because the housing conditions are not ideal* (II3).

> […] *the physical space did not benefit much because the house was very small, the walls were very thin, so you could hear all the noise from outside, the conversations on the other side of the door, the television on...* (I1).

For some participants, it is not problematic to enter their homes through the screen of the device used, since in the context of confinement the health care provided would be a priority for them, which means that in the virtual meeting there is an openness without any questioning by the users so that the treating team can enter their homes:

> *We never questioned that someone would enter our home through the screen, that issue never crossed our minds, because we were always thinking about the benefits it would have* (U3).

The difficulty of having the usual in-person intervention implements, within the framework of virtual care, meant that certain materials and resources were managed by the same people or families. On some occasions, this situation was an inconvenience for carrying out the sessions since they were not always available:

> […] *another obstacle could be the materials that can be implemented in the sessions or in the practices that we are going to carry out if they do not have it* (I6).

Given this situation, some actions were taken to develop the interventions, such as managing the delivery of therapeutic materials to the users' homes:

> […] *on a couple of occasions, for example, I had to go to drop off materials at a house, to be able to carry out an intervention or a particular activity as we had planned* (D1).

Another measure adopted was to carry out intervention activities with materials that users had available in their homes, thereby preventing them from incurring unnecessary expenses, as well as protecting them from going out shopping with the risk of contagion that this implied:

> […] *we told them…. for this we need egg boxes, if they don't have them, it could be yogurt pots, if they don't have them, it could be a ball,... the main thing we focused on was that, not to go out and buy, we worried about the economic situation* (I2).

> […] *it's simple, rice, noodles that are always at home, images that are printed, tempered scissors, but nothing that is unaffordable* (IU4).

For the participants in this study, in some situations the family is presented as an obstacle to the intervention process, as indicated by the following stories that show that some family members interfered during the sessions:

> *For example, it happened to me in several situations that the user was in his bedroom, but on the other side his grandmother was listening, and suddenly she got into the session, and there a conflict happened between them* (I5).

Other participants affirm that families simultaneously present favoring and hindering behaviors, among the former are collaborative and well-treated families; and on the other hand, families that denied the presence of the user or did not respect the time and space allocated for care at home:

> […] *i think it is a bit of both, a facilitator and an obstacle, ... in some aspects families that were facilitators in every sense, they adapted in a very good way, they adapted to the schedules and there are others who were obstacles, ... they told us, you know that he is not there and the child was talking next to him and they told us that he was not there* (I2).

There are experiences in which families are considered fundamental for the adequate development of care given that they respected the schedules, were responsible with the activities and committed to the materials:

> […] *all the parents were super committed, they were next to the children and never interrupted the session or challenged the child, ... they were super responsible, they connected on time* (I3).

It also happened that some member of the family becomes a "cotherapist", who supports the activities and sometimes manages resources to generate the ideal conditions for virtual care:

> […] *what we did was give the person a role, where I explained everything he had to do, so that he could do it with his father, ... we sent him videos so that he could do them and we sent them to his daughter* (I4).

> […] *they send them from one day to the next, so on the day of the therapy I have everything prepared, ... if there are three activities, we have the materials for the 3 activities, ... now the progress depends on me* (IU3).

Likewise, it is important to highlight that the majority of people who supported the care process were women, an issue that reflects the feminization of care in the health field:

> […] *the mother was the co-therapist, what I couldn't do, it was the mother who had to help me do the session, for me they were like another partner to help me do the sessions* (DG4I9).

> […] *i am always with one of my daughters and granddaughters, they accompanied me at first, because I was almost sitting and I didn't move anywhere, so there was always a daughter who helped me, we went to the sessions, they cooperated with the exercises, they helped me* (IU1).

Another of the findings found in this study shows that telehealth allows significant achievements for users in their recovery process, among which independence in basic and domestic Activities of Daily Living (ADL) can be mentioned:

> […] *there is a great progression, in basic ADLs, in activities at home, in family relationships, those areas have been super enriching to discover that the therapeutic objectives are achieved and with perfect quality* (II3).

> […] *if you ask me how I started today, I think I'm 80% of my capacity, because that's when I started cooking, now I can make candies, I make kneaded bread, even in therapy with the girls from the University, we made bread one day* (IU1).

Telehealth, occupation and territory

This topic addresses the inclination towards in-person care over telehealth, as well as the latter's relationship with the notion of territory.

One of the outstanding aspects in the opinions of the participants indicates that this type of care provides emotional support in a context of social isolation and high levels of uncertainty:

> […] *so pleasant for us as a patient, because you approach the patient and you are interested, ... I felt supported and pleased with the attention of the young people* (IU4).

> […] *they felt accompanied, heard, protected, especially last year when everything was so unpredictable, a lot of anxiety* (II4).

Despite the positive evaluations that most of the participants in this study make of telehealth, the preference for in-person care over virtual care appears in the reports of users and team members:

> […] *in-person, because the professional is the right one and I am going to make mistakes at home when replying, when the professional is not in front of me* (UI5).

> […] *ideally, if you ask us, the ideal is OT in-person care, that's like first of all* (II2).

It is important to mention that telehealth does not adequately address aspects linked to the use of territories other than the users' home:

> […] *another thing that I think should be is the issue of network articulation, ... I think we have to solve it* (D3).

> […] *instrumental activities, going shopping, you can't, it's impossible, ... the groups where they participated, we will always know them, now through telerehabilitation it is not possible* (II3).

Discussion

The background that allows us to understand telehealth from an occupational perspective is scarce. In order to be consistent with the collaborative and collective methodology with which the data of this study was produced, this section is presented considering the notions of participation in telehealth as an occupation, collective occupation and occupational dislocation, since they allow discussion of the possible ways to understand telehealth from an occupational perspective that guided this study.

Participation in telehealth in confinement contexts is a very complex occupation

The results of this study allow us to recognize that participation in telehealth can be understood from the perspective of the users as an efficient occupation for the management of health care and activities of daily living when they are the family members who participate as co-therapists and caring for others, especially when in periods of confinement people were reluctant to receive in-person care for fear of contagion (Priyadharsini & Chiang, 2020; Luck et al., 2022). In any case, it is important to note that there are participants who long to resume in-person care since virtuality does not suit them.

The results presented allow us to point out that telehealth became an efficient strategy so that teachers and health officials could continue their work activities. Simultaneously, they realize that participation in telehealth by students in the final year of their degree is a useful and effective virtual service-learning methodology; which allowed them to develop personal skills (Sandoval-Pérez et al., 2021), such as frustration tolerance and flexibility; teamwork (Godoy-Pozo et al., 2021), when seeking communication and mutual support strategies with teachers, users, family members and teams; social awareness (Ruiz-Corbella & García-Gutiérrez, 2020), by identifying socioeconomic difficulties and their implications on the daily lives of the people served; and the ability to plan and implement intervention methods specific to the discipline, perfecting digital skills (Culcasi et al., 2021), through the use of tutorial videos, applications and other information and communication technologies.

The findings of this study allow us to affirm that virtuality would present an important potential for the maintenance and access in the participation of occupations

such as work, education, health and care, at the same time it allows us to understand how people organize their routine, maintain roles, they look for alternatives to maintain contact with the outside world and how they give meaning to their lives.

In other words, in a context in which social relations were hegemonically mediated by digitalization, participation in telehealth offered the possibility of humanizing life, and in this fact is where the greatest contribution of virtualization is found, since it becomes a vehicle that encourages participation in meaningful occupations.

Home and telehealth: the flip side to the occupational dislocation experienced

At home, emotional support is received, deep knowledge is produced among its members and care is provided, at the same time, negative affects are expressed, conflicts and discrepancies occur (Rodríguez Salazar & Rodríguez Morales, 2020). These characteristics were possible to observe as this study progressed, since through participation in telehealth, various family behaviors were identified, some of them were facilitators, others were obstacles, and others presented both behaviors around the intervention process. An issue that had direct effects on its effectiveness, since to the extent that there is greater empowerment of family members, the therapeutic results of this strategy improve (Wallisch et al., 2019).

Through this study, it is possible to identify that many homes were not an optimal place to develop virtual activities such as telehealth, since the participants' homes present structural conditions that facilitate overcrowding (Fuentes, 2020; Parada-Lezcano et al., 2022), affecting the privacy of the users during the development of the sessions, which, as pointed out by Souza et al. (2013) is considered one of the weaknesses of the use of telehealth. The above was reflected in the lack of an adequate space in the home to receive care, the lack of privacy to discuss personal issues and the involvement with inappropriate comments from family members in the intervention given that they heard what was happening there.

The findings also show that the home is a place in which the devalued care work carried out by women has been historically reproduced. As Cavallero & Gago (2022) affirm, in this space a confinement occurs in four walls ordered by patriarchal hierarchies, which produces an overexploitation of the domestic space accentuated in times of pandemic, due to the hyper concentration of occupations that took place in that space, which included domestic, parenting, work, marital, among others.

In contexts of confinement, there are restrictions on the circulation of life, since occupations stopped taking place in the territories where people usually carry out their daily lives (Farías & Lopes, 2021), to which telehealth would not be able to reach. From what Bianchi & Malfitano (2021) affirm, we can point out that during the COVID-19 pandemic, the home was the territory where life circulated, interpersonal relationships were transformed, and intense emotional experiences developed. An issue that without social and health restrictions would probably occur in other territories designed to offer meaningful occupational experiences such as the neighborhood, school, universities, work, health care centers, among others.

In this sense, the occupational interruption as a result of the socio-sanitary measures to control the pandemic, and the reconfiguration of occupations in homes observed in this study, result in our opinion in a new form of occupational dislocation

(Pizarro et al., 2018); since it meant the temporary denial of territories other than the home, making it difficult to participate in meaningful occupations (Pizarro & Whiteford, 2021), in the ways that people are used to doing it, such as community, recreational, and instrumental ADLs, an issue that could lead to the loss of emotional ties and the sense of belonging to social groups other than the family. However, at the same time, this study shows that telehealth would be a means to maintain participation in significant occupations that are carried out in private territories due to the pandemic, such as education, health and work, an issue that was possible thanks to the fact that through virtuality, people exploited their capacity for creativity, resilience and reinvention of social ties (Kiepek et al., 2019; Freire-Pérez, 2021), skills that flourished in the digital encounter with others, in difficult moments such as the confinement experience lived.

Telehealth as a collective occupation

Whiteford (2007) and Valderrama (2019) affirm that collective occupations allow people to stay connected to each other, materialize the possibility of having socio-emotional support, and allow collaboration in search of well-being. For their part, Barlott et al. (2023) and Lee et al. (2022) point out that in contexts of confinement, technology was embodied in people's daily lives because it was the available means to maintain social ties and relationships. Based on these arguments and together with the experience analyzed, we propose that telehealth can be understood as a collective occupation, since participation in it became the driving force that shaped the forms of interaction of people and their relationships with others and determined the articulation and disarticulation in the participation of occupations. At the same time, the people involved dialectically configured the future and meaning of this virtual activity, and with this, gave meaning to the development of occupations mediated by digitalization. The above is expressed in the fact that the participants used in an intentional and coordinated manner, and even received training when they did not know how they were used, all the available means to keep in touch with others and seek and provide help, such as email, WhatsApp application, video conferencing platforms, digital devices such as cell phones, tablets, notebooks, among others.

Based on what Valderrama et al. (2019) affirm that the people who make up collective occupations meet and fight together to define for themselves the ways to carry out their healing processes. The findings of this study allow us to reinforce the proposal that telehealth is a collective occupation, since in this study, during their participation there is an appropriation of the intervention by the users in the context of their daily lives; that is, they themselves and their families become co-therapists or their own therapists during the digital care process, offering ideas, learning techniques, preparing materials and/or self-managing resources.

Simaan (2017), as well as Valderrama et al. (2022) propose that collective occupations are expressions of the different ways in which people generate resistance and are capable of re-existing in situations of adversity; in this sense, through the results presented we can point out that participation in telehealth allowed us to cope with the moments of anguish, pain, worry and hopelessness present during the COVID-19 pandemic, since it meant the possibility of meeting other people, share

their discomforts and joys, receive and give help, solve problems and give hope, creating a virtual collective occupation in which students, teachers, users, family members and care teams participated collaboratively.

Conclusions

The occupational perspective that guided the development of this study helps to understand participation in telehealth as a virtual collective occupation that allows reinvention in times of occupational interruption and potential new forms of occupational dislocation. In this way, the usefulness that virtuality provides in people's occupational experience is deepened, since it allows attention to be framed in the concrete realities of the users and their families, at the same time, it provides the possibility of identify their potential and limitations in vulnerable populations.

It is recommended to develop research in populations that are far from urbanization cones and that may present connectivity and digital info-literacy difficulties, in order to identify the benefits that occupational therapy offers through telehealth in rural areas, putting emphasis not only on the effectiveness of said strategy but on the meanings that users give to its use. The identification of sociocultural facilitators and obstacles present in the telehealth process in these territories can also be considered a complementary line of research.

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