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FEATURE ARTICLE

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How the occupational balance of healthcare professionals changed in the COVID-19 pandemic: A mixed design study

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Abstract

Background: Although it has been possible for many people to make a gradual transition to normal life or routine activities, the same seems far off for healthcare professionals. The current study examines in depth how the occupational balance of healthcare professionals has changed in the COVID-19 pandemic.

Methods: The current study has a mixed design, which involves collecting both qualitative and quantitative data. In the first stage of the study, which is the quantitative one, Turkish Occupational Balance Questionnaire (OBQ11-T) was used to collect data, whereas the second stage of the study, which is the qualitative one, was designed to explore occupational balance and the related issues via using semi-structured interviews. The Mann–Whitney *U* test was used to compare parameters between the groups (working in active–passive contact with COVID patients). On the other hand, qualitative data were evaluated via consensual qualitative data analysis.

Results: The level of occupational balance of healthcare professionals included in the study group was found to be significantly lower than the level of occupational balance of healthcare professionals included in the control group ($P = .005$). Although there was no clear problem in self-care activities of healthcare professionals, the balance between productivity and leisure time activities was disrupted.

Conclusions: Occupational balance and leisure time use of healthcare professionals, especially those who have active contact with COVID patients, have been affected. A further investigation can be carried out according to gender, age, and other demographic qualities.

KEYWORDS
coronavirus, occupational balance, occupations, time using

1 | INTRODUCTION

Coronavirus (COVID-19) emerged in Wuhan, China, in December 2019 (Vieira et al., 2020). It was declared as a pandemic by the World Health Organisation (WHO) on 11 March 2020, and it has had extensive effects on social life globally (Knorst et al., 2021). Measures taken to reduce contact and maintain physical distance have limited interpersonal relationships. Hard and partial lockdown and quarantine have caused a shift towards

online education and remote work, changing people's behaviours and habits drastically (Özden & Parlar, 2021; Vasiliu et al., 2020). In this period, people's roles, routines, habits, and lifestyles have changed significantly (Balser et al., 2020; Gehman, 2021). These changes have prevented many people from participating in activities and occupations they value, making it difficult to establish an occupational balance within their roles and routines (Agbaria & Mokh, 2021; Gehman, 2021). Consequently, the COVID-19 pandemic has had great negative effects on individuals' occupational participation (Jensen et al., 2021).

Occupations cover the activities and tasks that involve meaning and value for individuals, connected with their life roles and fulfil their own inner needs. There are different performance areas such as self-care activities, work and productive activities, and play and leisure activities (Roley et al., 2008). In order for these activities to be conducted in harmony with each other, occupational balance must be established. Occupational balance is a multidimensional concept that emerges depending on the level of participation in occupations, the proportionality of the time allocated to these occupations, the compliance of the occupations with social norms, and the fulfilment of roles (Eklund et al., 2017; Eklund & Argentzell, 2016). Occupational balance is an important concept and is usually the centre of attention within occupational therapy interventions (Wagman et al., 2017; Yazdani et al., 2018). Occupational therapists hold the view that occupational balance is the foundation of health promotion and well-being. Occupational balance enables the person to develop their identity and roles through participation in various activities, which in turn provides socialisation and increases well-being (Håkansson et al., 2011; Wagman et al., 2012).

The rapid spread of COVID-19 has created difficulties in healthcare systems. By the late 2020s, 300,000 cases of COVID-19 had been reported in Turkey. Healthcare professionals had to cope with stressors such as lack of protective equipment, deaths associated with COVID-19, fear of transmitting the virus to family members and loss of colleagues in this period (Hall, 2020). Working and risk conditions varied among the healthcare professionals who were in direct contact with COVID-19 patients and those who worked in less risky situations. For example, healthcare professionals exposed to SARS-CoV-2 infected patients in the emergency rooms, infectious wards, and intensive care units had a much higher risk of anxiety, depression, and sleep disturbances than healthcare professionals working in other wards (Wang et al., 2021; Wańkowicz et al., 2020). Additionally, healthcare professionals, who had higher-than-normal mortality rates, had to cope with long-term separation from their families, adapt to changing work practices and procedures, and manage fatigue caused by protective equipment and higher-than-usual working tempo (Brooks et al., 2020; Lai et al., 2020).

Healthcare professionals put extra effort into performing their activities and roles at home, both at work and after work (Wagman et al., 2017). The perspectives of occupational therapists working in health institutions regarding the factors that increase stress levels were examined, and they stated that a high level of stress was caused by an imbalance between these activities (Clouston, 2014). Wagman et al. (2017) states that factors that cause occupational imbalance for healthcare professionals and the ways to reach occupational balance should be investigated. Healthcare professionals are one of the most affected groups during the pandemic. They are trying to adapt to the pandemic while simultaneously becoming a workforce that is more important and in demand than ever before (Hammell, 2020). It is important to develop an understanding of how healthcare professionals perform their dual roles during the pandemic. Today, it seems more important than ever before that healthcare professionals achieve a balance of occupation as they adapt to the pandemic and create strategies that will help this adaptation (Hammell, 2020; Ornell et al., 2020).

The importance of occupational balance is frequently mentioned in the related literature; however, evidence-based studies examining the occupational balance of healthcare professionals are limited. Although many people have managed to return to normal life or routine activities gradually, the same does not seem possible for healthcare professionals. It is not known how the occupational balance differs among healthcare professionals who take a more active role in the pandemic conditions compared with those working in areas where there is less contact with infected patients. This study aims to examine the occupational balance of healthcare professionals in the COVID-19 pandemic. Specifically, the study compares the occupational balance of those who actively work with COVID-19 patients and that of healthcare professionals who do not and explores changes in levels of occupational balance compared with the pre-pandemic period.

2 | MATERIAL AND METHODS

2.1 | Study design

The current study has a mixed method design, which includes collecting qualitative and quantitative data together (Almalki, 2016). The mixed method approach is

well suited to answer the research questions guiding this research. In the quantitative stage of the study, the Turkish Occupational Balance Questionnaire (OBQ11-T) collected data specific to the healthcare professionals' level of occupational balance. Following this, semi-structured interviews collected qualitative data that explored the occupational balance and related issues in more depth and revealed the participants' unique experiences of working in this environment. The evaluations were conducted from September 2020 to December 2020, following the approval of the Ethics Committee.

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2.2 | Study population

Invitations to participate in the study were shared via online channels (Facebook/Twitter) and through personal communication channels (e-mail, messages). This snowball sampling method supported recruitment of study participants representative of healthcare professionals from various vocational groups working in different state hospitals (different cities/locations). The sample size was not predetermined, and an iterative approach of simultaneous data collection and analysis was adopted until reaching data and time saturation. The working individuals included in the study were those in direct contact with the risk groups such as COVID-19 outpatient clinics, wards, and filiation teams, whereas the control group consisted of healthcare professionals working outside of the pandemic services (e.g. therapists and dieticians) After the invitation, out of 350 healthcare professionals interviewed, 230 agreed to participate in the study, and 24 of them subsequently met the exclusion criteria: part-time employees ($n = 12$), those who were on a special leave (e.g. maternity leave) ($n = 4$), those under the age of 18 ($n = 3$), remote professionals ($n = 3$) and those who did not complete the study ($n = 2$). A total of 206 individuals, 105 of whom were working and 101 were not working during the pandemic, were included in the study. Because the job structures, requirements, and characteristics of each occupational group could differ, the qualitative interviews aimed to include at least 20 individuals from each occupational group. Qualitative interviews with 171 participants were completed (September 2020 to December 2020).

2.3 | Instruments: Socio-demographic Form

Participants who volunteered to participate in the study were screened for inclusion by online completion of the Socio-demographic Form. The Socio-demographic Form collected information from healthcare professionals such as age, gender, vocation, work time, work schedule, and shift cycle.

2.4 | Instruments: Occupational balance questionnaire (OBQ11-T)

Participants completed the OBQ11-T occupational balance questionnaire as an online form. The purpose of the scale is to measure satisfaction according to the amount and diversity of the daily occupations of the individual and to define the occupational balance according to the results obtained (Wagman & Håkansson, 2014). For the latest 11-item version of the test, a Turkish validity and reliability study was conducted with 0.922 test and retest coefficient and 0.785 Cronbach alpha (Günal et al., 2020). Each item in the scale is scored on a 4-point Likert scale (0–3) that varies between "strongly disagree" and "strongly agree". The total score ranges from 0 to 33 with the addition of each item, with higher scores indicating a higher occupational balance (Håkansson et al., 2020).

2.5 | Semi-structured interviews

This study, which aimed to investigate in depth how healthcare professional's occupational balance has been affected during the pandemic period, required an intensive qualitative interview process. Consensual qualitative research (CQR) analysis, a qualitative methodology developed by Rhodes et al. (1994), was selected (Hill et al., 1996; Rhodes et al., 1994). CQR is a constructivist approach that allows participants to build their own facts and their own internal experiences, although researchers use a consensus process to analyse data (Hill et al., 2005). Following the specific guidelines for conducting CQR (Hill et al., 2005), semi-structured interviews conducted at a time mutually arranged to best suit the work schedules and conditions of the participants thus supporting a comfortable interview. The four authors (GG, KÖ, GZ, DA) completed the interviews using online videoconferencing (Zoom/Skype) technologies. Each meeting lasted for about 30–40 min. The participants were asked for permission to record the interviews, and the audio and video recordings of the interviews were obtained upon the participants' consent. Voice writing (dictation) feature of the Microsoft Word was used to transcribe the audio and video recordings of the interviews.

Semi-structured interview questions are presented in Appendix A.

2.6 | Data analysis

2.6.1 | Quantitative data

SPSS software Version 24 was used to carry out the statistical analyses. The variables were investigated using visual (histograms, probability plots) and analytical (Kolmogorov–Smirnov) methods to see whether they displayed a normal distribution. Descriptive analyses were conducted using medians and interquartile ranges (IQR) for the non-normally distributed and ordinal variables. Because the data such as occupational balance were not normally distributed, non-parametric tests were conducted to compare these parameters. Healthcare professionals working actively with COVID-19 patients were determined as the study group (SG), whereas those without direct contact with COVID-19 patients were determined as the control group (CG). Parameters between the groups (SG and CG) were compared via the Mann–Whitney *U* test.

2.6.2 | Qualitative data

The interview recordings of the qualitative stage of the study were transferred to Microsoft Word files. The five authors of the current study used the consensual method to compare the data among cases in order to determine the domains and core ideas for each case and to generalise the findings within the sample. CQR analysis was used to evaluate the qualitative data: (a) trustworthiness of the method; (b) coherence of the results; (c) representativeness across samples; (d) testimonial validity; and (e) applicability of the results as recommended (Hill, Thompson, & Williams, 1997). A total of five researchers, including one professor, two lecturers and two occupational therapists working in a public hospital, conducted this analysis.

2.6.3 | Consensus coding

Hill et al. (1996) suggest that researchers find key ideas within domains defined by CQR, which can be categorised into themes at the centre of the consensual qualitative analysis. They state that this methodology "reduces the potential bias inherent in the use of a single judge and produces a richer conceptualization of the phenomenon (p. 209)." The research team worked collectively to create an environment where each team member could openly share their ideas and perspectives. When differences emerged, they analysed the data once more to present evidences for their ideas, eventually reaching a consensus after discussing the themes and variables. Initially, the team independently used open coding techniques to assign each meaningful piece of data (adjoining text on the same topic) to predetermined domains (Spradley, 1979). After completing independent coding of data to create domains, the authors met to discuss how each unit should be coded. Then, each author independently read all the data for a given case within each domain and wrote down the "core ideas," and then the whole team discussed to reach a consensus about each core idea. A consensus version was developed using agreed-on core ideas and exact quotes. Cross-analysis was performed. Based on the key ideas in the field for each question, the team looked for similarities in the key ideas. They then categorised similar basic ideas in each case (in every field) under themes. After identifying the themes, the team reviewed all interview data to make sure the key ideas were present and correct. Themes and sub-themes were determined for each interview question. Because the number of individuals interviewed was high, the qualitative data were presented in percentage expressions to make it easier to understand. The data including the themes, sub-themes and related participant expressions were summarised into tables by the authors. Details on the resulting themes are summarised in Appendix A.

2.7 | Ethical consideration

Before the authors of the current study started to conduct the study, they obtained approval from Ethics Committee at Biruni University Non-Invasive Clinical Investigation Ethics Committee. It was also examined by the Ministry of Health, and the study conducted in the COVID-19 pandemic was found to comply with the regulation (file number: 12T13_57_30). The procedures used in this study adhere to the tenets of the Declaration of Helsinki. All respondents and their signed online informed consent forms for participation.

3 | RESULTS

3.1 | Participant profile

Participants were allocated to the SG including healthcare professionals working actively during the COVID-19 pandemic ($n = 105$) and the CG group, which included healthcare professionals not working actively ($n = 101$) in this period. As depicted in Table 1, the SG included 78 (74.3%) female and 27 (25.7%) male participants with a mean age of 30.7 (standard deviation [SD] = 5.8) years.

The CG included 73 (72.3%) female and 28 (27.7%) male participants with a mean age of 31.8 (SD = 6.2) years. No significant differences were found between the groups regarding age, gender, marital status, and caregiver role ($P > .05$). The participants' demographic characteristics are presented in Table 1.

3.2 | Healthcare professionals' working conditions

As depicted in Table 2, healthcare professionals in the SG worked a mean 6.6 (SD = 2.9) months during the pandemic. Additional findings about healthcare professionals' work conditions are presented in Table 2.

Fifty-nine (56.1%) participants in the SG and 46 (43.8%) participants in the CG had been infected with COVID-19.

The analysis of the participants' professions revealed that nurses constituted the largest group in the SG, whereas other healthcare professionals constituted the largest group in the CG. Distribution of all professions within the SG and CG is given in Figure 1.

3.3 | Healthcare professionals' occupational balance

The mean score of total occupational balance in the SG was 9.2 (SD = 5.2), compared with 11.5 (SD = 5.8) in the

TABLE 1 Participants' socio-demographic qualities

	Study group ($n = 105$)		Control group ($n = 101$)			
	Range	**M (SD)**	**Range**	**M (SD)**	***Z***	***P*-value**
Age (year)	23–50	30.7 (5.8)	24–53	31.8 (6.2)	−1.814	.214
	Frequency (%)		**Frequency (%)**			
Gender						
Female	78 (74.3)		73 (72.3)			
Male	27 (25.7)		28 (27.7)			
Marital status						
Single	55 (52.4)		55 (54.5)			
Married	50 (47.6)		46 (45.5)			
Caregiver role						
Yes	48 (45.7)		38 (37.6)			
No	56 (53.3)		48 (47.5)			

Abbreviation: M (SD), mean and standard deviation.

TABLE 2 Participants' working conditions

	Study group ($n = 105$)		Control group ($n = 101$)	
	Range	**M (SD)**	**Range**	**M (SD)**
Working experience (year)	1–27	7.7 (6.9)	1–30	8.4 (8.4)
Working time weekly (hour)	8–96	48.3 (14)	1–96	38.5(14.8)
Working time pandemic (month)	1–10	6.6 (2.9)	-	-
	Frequency (%)		**Frequency (%)**	
Enough break				
Yes	49 (46.7)		53 (52.5)	
No	56 (53.3)		48 (47.5)	
COVID-19				
Infected	59 (56.1)		28 (43.9)	
Not infected	46 (43.8)		73 (56.2)	

Abbreviation: M (SD), mean and standard deviation.

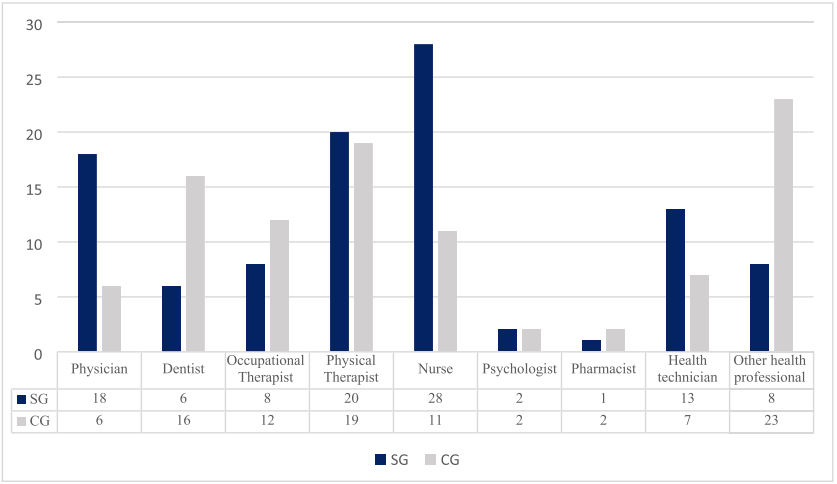

FIGURE 1 Participant vocations in both groups. CG, control group; SG, study group

CG. The occupational balance of the healthcare professionals in the SG was found to be significantly lower than that of healthcare professionals in the CG ($P = .005$) (Table 2).

When the occupational balance of healthcare professionals was examined based on the amount of breaks they had, it was identified that individuals who did not have enough breaks had a significantly lower level of occupational balance ($P < 0.001$) (Table 2).

The level of occupational balance of healthcare professionals infected with COVID-19 was found to be lower than that of healthcare professionals who had not been infected with COVID-19 ($P = .006$) (Table 2).

3.4 | Qualitative findings on occupational balance

The participants' descriptions of how they managed their daily life with work and other occupations were consistent with the predefined themes:

1. self-care activities,
2. productivity activities,
3. recreational activities,
4. personal factors,
5. environmental factors.

CQR presents the results in terms of general and typical results. An overall result means that the theme is prominent in the responses of participants. This section presents general and typical findings by theme. Qualitative findings on occupational balance are presented in Appendix A.

3.4.1 | Theme 1: Self-care activities

According to one of the sub-themes of this theme, healthcare professionals' self-care, functional mobility, and community management activities were affected negatively. Thirty-six percent of the participants stated that their personal activities changed during the pandemic period. The typical results included problems in self-care activities due to reasons such as sleep deprivation, depression, stress, and tiredness. Self-care activities included personal care (feeding, sleeping), functional mobility (transfers, indoor, outdoor), or community management (shopping). One participant said, "My daily routine is going to work and eating on the days when I work. When I don't work, I usually sleep. Sleeplessness becomes quite a problem during heavy work" (Participant 95). Another participant said, "I can't take care of myself sufficiently because of a bad mood due to the COVID infection transmitted from the hospital as well as sleep disorders and psychological problems" (Participant 18).

3.4.2 | Theme 2: Productivity activities

According to one of the sub-themes of this theme, healthcare professionals' paid work, household management, and school activities were affected negatively. Roughly 40.7% of the participants stated that the reason for the deterioration in occupational balance was the "increase in workload." One participant said, "I think it's broken. The workload is heavy. Because we have been working at the same place for a long time. I feel tired both physically and psychologically. This situation affects

the participation in my activities, and therefore I participate in such activities less. I don't feel like doing anything" (Participant 36). Also, participants stated that they had difficulty in doing household chores (%25.24). Carrying out both chores and their children's educational activities was a trouble for the participants. On the contrary, the time spent in work-related activities increased (Table 3).

3.4.3 | Theme 3: Recreational activities

According to one of the sub-themes of this theme, healthcare professionals' active and passive recreation activities were affected negatively. Fifty-four percent of the participants stated that they had difficulty in social activities. One participant said, "I can't see my family. My social activities are completely over" (Participant 38). It was stated that among the recreational activities, the most restricted areas were doing sports, spending time with friends or family, and going to the cinema, cafe, or theatre. Another participant said, "Before the pandemic, I used to exercise every day, now I almost never do it" (Participant 67).

3.4.4 | Theme 4: Personal factors

Fifty-seven percent of the participants stated that their occupational participation and range of activities were negatively affected, as they feared the risk of carrying the disease to their family or beloved ones. A participant said, "The time we spend between hospital and home has increased even more due to COVID-19 for 8 months. Since I am a healthcare professional, I unwittingly avoided many activities in order not to be in crowded environments in society and not to infect others if I have the disease" (Participant 84).

3.4.5 | Theme 5: Environmental factors

According to one of the sub-themes of this theme, healthcare professionals' physical environment and institutional environment negatively affected thier occupations. Participants stated that their activities were negatively affected by the risky business environment and the long hours they spent in the workplace. Also, the majority of the participants stated that their social activities were negatively affected because of the measures/restrictions taken by the state due to the pandemic. One participant said, "Working hard, working with a mask and special clothes is extremely tiring, your mind is full of fear. The enormous stress is already exhausting for your soul, heart and body. With these factors, even when taking a bath can be impossible, which occupations can be done in a balanced way?" (Participant 58).

4 | DISCUSSION

The findings reveal that healthcare professionals who are actively working in the pandemic cannot come together with their families, their self-care activities are affected, the time they spend in the workplace has increased, leisure time activities are limited, and thus their occupational balance is negatively affected. During the pandemic, most healthcare professionals have faced problems such as heavy workload, stress, fatigue, perceived insomnia, and perceived depression. Factors such as exposure to risk, fear of infecting their beloved ones and families, lack of protective equipment (Lai

TABLE 3 Findings related to occupational balance

	Study group ($n = 105$)		**Control group ($n = 101$)**			
	Range	**M (SD)**	**Range**	**M (SD)**	***Z***	***P*-value**
OBQ11-T total	1–23	9.2 (5.2)	1–24	11.5 (5.8)	−2.781	.005*
	Enough break (yes) ($n = 102$)		**Enough break (no) ($n = 104$)**			
	Range	**M (SD)**	**Range**	**M (SD)**		
OBQ11-T total	2–24	12.4 (6.2)	1–23	8.2 (4.8)	−5.004	<.001**
	Infected COVID-19 ($n = 87$)		**Not infected COVID-19 ($n = 119$)**			
	Range	**M (SD)**	**Range**	**M (SD)**		
OBQ11-T total	1–24	8.6 (5.1)	1–24	11.9 (5.9)	−2.285	.006*

Abbreviations: M (SD), mean and standard deviation; OBQ11-T, Occupational Balance Questionnaire.
*$P < .01$. **$P < .001$.

et al., 2020), physical fatigue in long-term use of protective equipment, limited resources (Çankaya, 2020), and busy working hours (Nakata et al., 2012) are important factors that affect healthcare professionals' mental health and psychological well-being (da Silva & Neto, 2020). A study conducted by Çankaya (2020) reveals that healthcare professionals' well-being during the pandemic was worse than the time before the pandemic. Similarly, our findings show that the level of occupational balance of healthcare professionals who took an active role during the pandemic was lower than those who did not take an active role. These findings have emerged as a result of the analysis of both quantitative and qualitative data. Though the OBQ11-T questionnaire showed a significant difference between the groups, the participants of the qualitative stage mentioned that their occupational balance was affected badly. In addition, our results allow comparison between healthcare professionals. The group of healthcare professionals working most actively during the pandemic is composed of nurses. They took a more active role in the pandemic compared with other healthcare professionals, and their occupational balance was disturbed. Another important finding of the current study is that the level of the occupational balance of the individuals who took sufficient breaks during the work was found to be higher. This finding is valuable to occupational therapists as long working hours are important to the health, well-being, and performance of professionals (Shoja et al., 2020).

Zafran (2020) categorised the activities people most need and tend to do during the time when they adapt to the pandemic. These activities include engaging in activities (phone calls, online training, virtual chats), centre-oriented activities (yoga, meditation, long walks), creative activities (drawing, writing, painting, singing), thought-provoking activities (contemplation, prayer, yoga, journaling), and contributory activities (carrying out projects, reaching those in need). The participants in our study stated the activities they started to do frequently during the pandemic were housework (cleaning, cooking), passive recreation (watching television, reading books), domestic activities (handicraft, hobby), and productivity activities (work, study, online courses). Although healthcare professionals turned to new activities during the pandemic, their occupation and role balance was destroyed. In our study, most of the healthcare professionals stated that their self-care activities did not change during the pandemic. Those who had problems in self-care activities stated that they could not spare as much time as before for these activities due to reasons such as perceived insomnia, depression, stress, and fatigue. Among the self-care activities, the most affected area was especially sleeping. In the study by da Silva and Neto (2020), it was found out that one of the most common problems experienced by healthcare professionals is insomnia and that insomnia is a risk factor for anxiety and depression.

The study by Shoja et al. (2020) showed that the total workload of healthcare professionals who took an active role during the pandemic was significantly worse than other employees. However, the increase in the working hours of healthcare professionals is one of the important factors affecting their level of anxiety (Nakata et al., 2012). Similarly, healthcare professionals stated that their workload increased, the time spent on work activities increased, and they had to work at weekends and have night shifts, which resulted in increased responsibilities, professional burnout, occupational atrophy, and unprofessional duties. In particular, they stated that the change in job descriptions was the most influential factor on productivity activities.

According to a study conducted in Sweden, female healthcare professionals spend twice as much effort in housework than men, and their participation in leisure time activities is restricted (Wagman, 2017). When we look at family roles in Turkey, it is known that women take more responsibilities (Günay & Bener, 2011; Taylan, 2009). In our study, female healthcare professionals who actively worked during the pandemic time stated that they could not devote much time to housework and could not support the educational needs of their children due to the increasing burden in the workplace. This makes it more common among women to have a destroyed occupational balance. We think that organising family roles as well as sharing and improving women's working hours will contribute to their occupational balance.

Håkansson et al. (2020) emphasised that level of satisfaction and balance at work as well as productive and leisure activities affect people's life satisfaction, so occupational therapists should focus on issues such as occupational balance and meaning of occupations. Pandemic conditions have also affected the leisure activities of healthcare professionals. Socialisation in particular was one of the most affected areas. Individuals stated that they stayed away from their families, they could not see their beloved ones for a long time, and they mostly turned to online meetings. In addition, leisure time activities mostly focused on passive activities such as reading books and watching television. Leisure time activities were organised in China to help the staff working in the pandemic to reduce their stress (Lai et al., 2020). We think that such practices are important to ensure the occupational balance of healthcare professionals and should be implemented routinely. Healthcare professionals working actively in COVID-19 services stated that there was a work–family conflict, difficulties in how to

manage due to changes in the workforce, and conflicts arising from not being able to fulfil their roles fully (Baki & Piyal, 2020). Similarly, our findings show that healthcare professionals have difficulty in maintaining occupation–role balance. Most of them have changed in their parental, family, social, and professional roles compared to the time before the pandemic. They spend less time with their family and relatives due to reasons such as the anxiety of infection, increased workload, and fatigue. Emotional reactions such as stress, sadness, restlessness, and anger are observed in employees with the change of occupation-role balance. On the other hand, healthcare professionals who have a role as a parent stated that the time they spent with their children increased during the day and they were able to devote more time to housework due to the flexible working hours and online education at schools. Similarly, in the study by Sethi et al. (2020), some of the healthcare professionals stated that they could devote more time to themselves, their family, and their work during this period.

We conducted our study 6 months after the beginning of the pandemic. As time passed, the severity of the disease and chronic work fatigue increased. Due to prohibitions and closures, well-being decreased, fear and stress increased with the increase in the rate of spread, and situations such as dismissals were observed. We think that this situation affects the occupational balance more negatively. However, subjective reasons such as personal characteristics, spirituality, helping people, habits, the desire to be a part of a group, and the sacred perspective towards the profession help healthcare professionals cope with stress, reduce their fears, continue to work despite intense tempo, and maintain their activity balance. We propose detailed studies investigating what affects the balance of activity.

5 | LIMITATIONS AND FUTURE RECOMMENDATIONS

The current study has some limitations. Because of both the conditions during the pandemic and the busy working pace of the participants, interviews were conducted online. The use of online interview techniques made it easier to reduce the risk of disease transmission and to reach a wider group of healthcare professional from different regions. Also, collecting data through technological means was easier than expected. However, this method had some disadvantages. For instance, the duration of the calls was limited with some videoconferencing applications, and some participants had limited Internet access. Face-to-face interviews could increase the contribution of the participants in the qualitative interview. Another limitation was that the distribution of the participants by profession was not equal. For future studies, how the occupational balance changes according to gender, age, and other demographic characteristics such as professions can be investigated in more detail. Detailed standardised tests on sleep, well-being, quality of life, job performance, and roles can be used, along with self-care, work-productive, and leisure activities, and sub-themes can be examined in more detail. During the pandemic, occupational therapists can provide healthcare professionals with psychological support and counselling as their occupation–role balance was disturbed.

6 | CONCLUSION AND CLINICAL IMPLICATIONS

During the COVID-19 pandemic, the occupational balance of healthcare professionals, who are working with great devotion, has been significantly affected. During this period, although there was no apparent problem in self-care activities of healthcare professionals, the balance between productivity and leisure time activities was disrupted. With increasing working hours and heavy workload, healthcare professionals devote most of their spare time to productivity activities. Quality leisure time activities cannot be done due to fatigue and psychological exhaustion in the remaining time when they do not work. In addition, with the restriction of outdoor activities and the increasing activities in the household, leisure time activities have gained a unidimensional nature, and the effect of this situation on healthcare professionals' level of satisfaction as well as their quality of life is a matter of discussion.

KEY POINTS FOR OCCUPATIONAL THERAPY

- The occupational balance of healthcare professionals has been significantly affected in the COVID-19 outbreak.
- Occupational therapists should engage in some activities to improve healthcare professionals' social participation, use of time, and self-care activities, especially if they work actively during the pandemic.

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CONFLICT OF INTEREST

The authors confirm that there is no conflict of interest.

AUTHOR CONTRIBUTIONS

All authors contributed to the development of the study methodology, data collection, and analysis. All authors participated in writing, reviewing, and editing the manuscript and approved the final version.

DATA AVAILABILITY STATEMENT

Data are available upon reasonable request from the corresponding author and are otherwise restricted for ethical considerations, as it was instructed by the ethical committee.

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APPENDIX A

QUALITATIVE FINDINGS ABOUT OCCUPATIONAL BALANCE ($n = 171$)

Q1: ***What are the routine activities in your daily life? When the pandemic started, which of these daily life activities did you have difficulty in performing?***

Performance areas	Before the pandemic	How to define during the pandemic?	Participant statements with the theme highlighted in bold
Self-care activities	• Personal care (feeding, sleeping) • Functional mobility (transfers, indoor, outdoor) • Community management (shopping)	36.2% of the participants state that their self-care activities changed during the pandemic period (36.2%) It was stated that **sleeping** was affected the most in self-care activities (38.7%)	"My daily routine is going to work and eating on the days when I work. When I do not work, I usually **sleep.** Sleeplessness becomes quite a problem during heavy work"
Productivity activities	• Paid work • Household management (cleaning, laundry, cooking) • Play/school (homework)	Participants stated that they had difficulty in doing household management (26.5%) Carrying out their own and their children's educational activities was a problem (18.7%) However, the time spent in business activities increased (35.7%)	**"Cleaning the house, cooking, spending time with my children** were my daily activities. After the pandemic, I have to give up one or two of them" "I cannot travel to a different city for **education** because my working hours have increased"
Recreational activities	• Active recreation (sports, travelling, going to the cinema/theatre) • Socialisation (meeting with friends)	The majority of the participants stated that they had difficulty in participating in social activities (55.2%) It was stated that among the recreational activities, the most restricted areas were: • doing sports, • spending time with friends or family, • going to the cinema/cafe/theatre, • outdoor activities	"I cannot go to **sports**, I cannot go out, I cannot **see my friends**, I cannot **take my baby outside**" "I cannot see my family. My **social** activities are completely over" "Before the pandemic, I used to go to the **gym** regularly every day, now I almost never do it" "We now spend less time in the forest and nature with children"

Q2: ***Which factors do you think may interfere with your daily life activities?***

	Factors thought to have a negative impact	Participant statements with the theme highlighted in bold
Personal factors	The majority of the participants stated that their participation in activities and range of the activities they could participate in were negatively affected, as they feared carrying the disease to their family or beloved ones (56.5%)	"Our time between hospital and home has increased even more due to covid-19 for 8 months. Since I am a healthcare professional, I unwittingly avoided many activities in order not to be in crowded environments in the society and **not to infect others** if I have the disease"
Environmental factors	**Physical environment:** Participants stated that their activities were negatively affected by the risky job environment and the long time they spent in the workplace (38.2%) **Institutional environment**: The majority of the participants stated that their social activities were	"**Working hard**, **working with a mask or special clothes** is extremely tiring, your head is full of fear. The enormous stress is already exhausting for your soul, heart and body. With these factors, even when taking a bath can be impossible, which activity can be done in a balanced way?!"

(Continues)

Q2: *Which factors do you think may interfere with your daily life activities?*

	Factors thought to have a negative impact	Participant statements with the theme highlighted in bold
	negatively affected by the measures/restrictions taken by the state due to the pandemic (62.5%)	"Many places are **closed** due to the pandemic, public events are **forbidden**, and often even going out is **prohibited**"

Q3: *Have you started to carry out new activities that you did not do before during the pandemic? If yes, what are these activities?*

Activities	Frequently stated categories	How to define during the pandemic?	Participant statements with the theme highlighted in bold
Not doing new activities	• Fatigue • Lack of motivation	The majority of the participants stated that they did nothing new (52.7%) They reported that the reason for this was fatigue and lack of motivation	"I just do the activities I used to do. Because I have no **motivation**" "I have a day off, and it passes with **rest**"
New activities	• Household management (cleaning, cooking) • Quiet recreation (watching TV, reading book) • Indoor activities (craft, hobby) • Productivity activities (paid work, class, online course)	Participants stated that they spent more time on activities carried out at home (craft, hobby, cooking, watching movies, reading books, yoga, Pilates, etc.) (36.5%) Participants reported innovations in productivity activities such as taking online courses (15.6%)	"I started to spend more time **in the kitchen**. I started making new dessert and pastry recipes" "We learned to spend more time **at home**" "During the quarantine, I was able to **read books** I could not read before" "I started learning Spanish with an **online course**"

Q4: *Has your occupational balance been disturbed during the pandemic? If so, what do you think are the reasons affecting this situation?*

Performance areas	Before pandemic	How to define during the pandemic?	Participant statements with the theme highlighted in bold
Self-care activities	• Personal care (feeding, sleeping) • Functional mobility (transfers, indoor, outdoor) • Paid work Community management (shopping)	Most of the participants' state that their occupational balance changed during the pandemic period (78.2%) It was stated that "self-care activities" were affected the most among all occupations (36.2%) Problems in self-care activities due to reasons such as sleep deprivation, depression, stress, and tiredness (12.3%)	"I am physically exhausted and cannot rest. I cannot **sleep**. That's why, I cannot do my **self-care activities** enough" "I **cannot care for myself sufficiently** due to a **bad mood** resulting from the COVID infection transmitted from the hospital, as well as **sleep disorders** and **psychological problems**"
Productivity activities	• Paid work • Household management (cleaning, laundry, cooking) • Play/school (homework)	40.7% of the participants stated that the reason for the deterioration in occupational balance is the "increase in workload" (40.7%)	"I think it's broken. The **workload** is **heavy**. Because we have been **working at the same pace for a long time**. I feel tired both physically and psychologically. This situation affects the participation in my activities and therefore I participate in such activities less. I do not feel like doing anything" "My **sleep pattern is disturbed**, and the intensity of **graduate courses** (remotely) causes me to **work late** into the night"
Recreational activities	• Quiet recreation (reading book,	It is seen that the participants prefer "quiet recreational activities" (reading books,	"I can no longer meet my friends outside. I **read a book** or watch TV at home"

(Continues)

Q4: ***Has your occupational balance been disturbed during the pandemic? If so, what do you think are the reasons affecting this situation?***

Performance areas	Before pandemic	How to define during the pandemic?	Participant statements with the theme highlighted in bold
	watching TV/movie) • Active recreation (sports, travel, going cinema/ theatre) • Socialisation (meeting with friends)	watching TV series/movies) after the pandemic (54.2%)	"Yes, it is broken, I **cannot exercise** with a mask" "My occupational balance is disturbed because we **cannot meet with our friends.** We cannot go to events such as **cinema**"

Q5: ***Did your work life change during the pandemic? If yes, how did these changes affect you?***

Performance areas	Before pandemic	How to define during the pandemic?	Participant statements with the theme highlighted in bold
Productivity activities	Spending less time with paid work Spending less time with household management (cleaning, laundry, cooking) Spending less time with play/school (homework)	**Paid work:** Participants stated that the change in the job description (increase in the number of seizures, taking part in the filming team, etc.) was the most influential factor on productivity activities (20.5%) **Household management:** It was stated that "increased fatigue in work life" affected household management the most (15.4%) **School:** "Flexible working hours" appear to make it easier to balance school and work (4.8%)	"I work more like a statistician, nurse, secretary and quality unit worker than an occupational therapist. I am working with a friend, who is a nurse, making it that there are 2 people working in a place where there should be 8 people working indeed. The **workload has increased**; I cannot focus on a single job" "The pandemic caused me to try to manage work-related situations at home, outside working hours. It has become **difficult for me to do housework**" "My working hours have decreased. Starting to do my **online lesson**s and working at the same time enabled me to do **better time management**"

Q6: ***What are your roles in everyday life (for example, being a mom, being a nurse)? Were there any changes in your roles in the pandemic? How did this situation affect you?***

Roles of everyday life	Before pandemic	Were any changes in your roles in the pandemic?	How did that change? How did this situation affect you?	Participant statements with the theme highlighted in bold
Parenting roles	• Mom • Dad	Yes (62.4%)	1. Emotional effect Stress Sadness Fear Boredom Uneasiness More tensioner Anger Introversion	"Since I cannot come home rested, I cannot fulfil my duties as a wife. As a mother, I cannot spare time for my children. As a family, all of us have deteriorated. My child has started primary school, I cannot help him with his homework because I come home **tired** in the evening"
Family roles	• Child • Sister • Brother • Wife	Yes (66.8%)	Fear of transmitting the disease to the parents 2. Difficulty in time management Spending less time with our family, children and loved ones	"As a child, I became more **angry and intolerant**, which was caused by spending too much time with my family"
Professional roles	• Doctor	Yes (72.6%)		"I **do not have a therapist role** anymore; I work actively in the

(Continues)

Q6: ***What are your roles in everyday life (for example, being a mom, being a nurse)? Were there any changes in your roles in the pandemic? How did this situation affect you?***

Roles of everyday life	Before pandemic	Were any changes in your roles in the pandemic?	How did that change? How did this situation affect you?	Participant statements with the theme highlighted in bold
	• Occupational therapist • Nurse • Health employer • Social worker		3. Challenge with role-activity balance 4. Physical effect Tiredness No rest 5. Lifestyle changes	field with Covid-19. It is sad to stay away from the field of therapy where I will apply my theoretical knowledge and practice"
Social roles	• Friend • Roommate • Boy/girlfriend	Yes (65.7%)	6. Impacted by the work load Inefficiency Professional blinding 7. 6 Positive changes in rolesMore time for homework Better for a child	"We could not meet with my lover during the quarantine. This caused unnecessary quarrels between us"

Q7: ***Have your job duties and responsibilities changed during the pandemic? How did it change?***

Changes in work	Categories	Participant statements with the theme highlighted in bold
Reducing responsibilities	• Transition to flexible working hours (17.2%)	"We switched to flexible working. We **go to work only on c**ertain days of the week"
Increase in responsibilities	• Increase in the number of working days and overtime hours (34.5%) • Increase in treatment time for patients (26.2%) • Increase in more intensive work due to heavy work load (36.2%) • Increase in physical fatigue (15.6%)	"I was working 8 hours a day before the pandemic. But now I **work 16 hours a day**. Our mission involves direct contact with Covid-19. It's more stressful, and there is a fear of getting sick"
Change in occupational and professional concept	• Working at the weekend (17.5%) • Night shift (28.6%) • Increase in professional burnout (18.2%) • Loss of profession as a result of being given different duties (not being able to do one's own job) (16.5%) • Additional non-professional assignments (35.6%)	"I am working more now than before the pandemic. While I was doing only my **own job before the pandemic**, now I am working as a secretary outside of my profession. I am professionally blunt"