Australian Occupational Therapy Journal

Occupational Therapy Australia

How the Occupational Balance of Healthcare Professionals Has Changed in the COVID-19 Pandemic: A mixed design study

Journal:	*Australian Occupational Therapy Journal*
Manuscript ID	AOTJ-2021-043
Manuscript Type:	Feature Article
Keywords:	occupational balance, healtcare professionals, COVID-19, pandemic

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Methods: A mixed design study was used, which included collecting qualitative and quantitative data together in this study. In the first quantitative stage, measurement tool Turkish Occupational Balance Questionnaire (OBQ11-T) was applied, the qualitative phase (using semi-structured interviews) was designed to explore occupational balance and related issues. The Mann– Whitney U test was used to compare parameters between the groups (Working in active-passive contact with Covid patients).
Results: The occupational balance of healthcare professionals with SG was found to be significantly weaker than healthcare professionals with CG (p=0.005). 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 health professionals, especially those who have active contact with Covid patients, should be supported by occupational therapists. According to gender, age and other demographic can be investigated in more detail.
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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 Organization (WHO) on 11 March 2020, and it 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 caused a shift towards online education and remote work, changing people's behaviours and habits drastically (Vasiliu et al., 2020; Özden & Parlar, 2021). In this period, people's roles, routines, habits and lifestyles have changed significantly (Balser et al., 2020; Gehman, 2021). This changes disabled many people to participate in activities and occupations they value, making it difficult in establishing an occupational balance within the frame of their roles and routines (Gehman, 2021; Agbaria & Makh, 2021). Consequently, the COVID-19 pandemic 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, 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 the occupations, the compliance of the occupations with social norms, and the fulfilment of roles (Eklund & Argentzell, 2016; Eklund et al., 2017).

Occupational balance is one of the most important concepts 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 provides socialisation, and increases wellbeing (Wagman et al., 2012; Håkansson et al., 2011).

The rapid spread of the disease has created difficulties in healthcare systems. By late 2020s, 300000 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 the fact of losing colleagues in this period (Hall, 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, manage fatigue caused by protective equipment and higher-than-usual working tempo (Lai et al., 2020; Brooks et al., 2020).

Healthcare professionals put extra effort into performing their activities and roles at home, both at work and after work. In a study conducted with healthcare professionals in Sweden, it

was found that female healthcare professionals spend twice as much effort in housework activities compared to men, and their participation in leisure activities was restricted (Wagman et al., 2017; Wagman et al., 2012; Wagman & Håkansson, 2014). The perspectives of occupational therapists working in health institutions regarding the factors that increase stress levels have been examined and they stated that it was caused by the imbalance between the activities (Clouston, 2014).

Wagman et al. stated that factors that cause occupational imbalance should be investigated and how to reach occupational balance should be investigated (Wagman et al., 2017). Healthcare professionals are one of the most affected groups during the pandemic. Simultaneously, healthcare professionals have become more important than ever during the pandemic and they are trying to adapt to this process like everyone else (Hammell, 2020). It is important to know the disadvantages, perspectives and how healthcare professionals perform their roles in participating in activities during the pandemic. Achieving a balance of occupation for the adaptation of healthcare professionals to the pandemic and creating strategies that will help this adaptation have gained importance today (Hammell, 2020; Ornell et al., 2020).

When the literature is reviewed, the importance of occupational balance is frequently mentioned; however, evidence-based studies examining the occupational balance of healthcare professionals are limited. For many people, although return to normal life or routine activities can be achieved gradually, it does not seem possible for healthcare professionals. In this study, it was examined in depth how the occupational balance of healthcare professionals has changed in the COVID-19 pandemic.

Material and methods

Study Design

A mixed design study was used, which included collecting qualitative and quantitative data together in this study (Almalki, 2016). The mixed methods approach was well suited for answering the research questions that guided this research. In the first quantitative stage, measurement tool Turkish Occupational Balance Questionnaire (OBQ11-T) was applied to determine the occupational balance levels of healthcare professionals and to compare balance levels of those who took an active role in the pandemic and those who did not. Following this, the qualitative phase (using semi-structured interviews) was designed to explore the occupational balance and related issues in more depth and to reveal the participants' unique experiences of working in this. The evaluations were conducted from September 2020 to December 2020, following the approval of the Ethics Committee. The research invitation containing the research content, purpose and method was shared with health proffesionals via online channels. The quantitative data of the study, including sociodemographic form and OBQ11-T, was collected via Google Forms, and the qualitative data was collected via online interview techniques (telephone conversation /Zoom/ Skype). Ethics Committee approval was obtained for the study from Biruni University Non-Invasive Clinical Investigation Ethics Committee and it was examined by the Ministry of Health and the studies conducted in the COVID-19 pandemic were found in accordance with the regulation (File number:12T13_57_30). The procedures used in this study adhere to the tenets of the Declaration of Helsinki.

Participants

The sample of the study consisted of healthcare professionals from various vocation groups working in different state hospitals with the snowball sampling method. The sample size was not predetermined, and an iterative approach of simultaneous data collection and analysis was

taken until data and time saturation were reached. After the invites, out of 350 healthcare professionals interviewed, 230 agreed to participate in the study and of these, 24 participants subsequently met the exclusion criteria: Part-time employees (n=12); using special leave (eg maternity leave) (n=4); Under the age of 18 (n=3); remote workers (n=3), uncompleted the study (n=2). A total of 206 individuals, including 105 working in the pandemic and 101 not working in the pandemic, were included in the study. Qualitative interviews were completed with 171 participants.

Instruments: Sociodemographic Form

The Sociodemographic Form included sociodemographic data of healthcare professionals such as age, gender, vocation, working time, working timetable, shift cycle.

Instruments: Occupational Balance Questionerrie (OBQ11-T)

The purpose of a scale measuring the occupational balance of the individual 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 (Håkansson et al., 2020; Günal et al., 2020). Each item in the scale is scored on a 4-point Likert scale (0-3) 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 professional balance (Håkansson et al., 2020).

Semi Structured interviews:

We applied a qualitative approach, phenomenology, to pool and analyse experiences reported by healthcare professionals. A phenomenological approach allows the investigator to distil the

essence of the experience by coding and categorising data to identify themes (Moustakas, 1994). The interviewer used open-ended probes to clarify incomplete or ambiguous responses. Telephone calls or online channels (Zoom/ Skype) were held according to the access status of the individuals. Each meeting lasted about thirty minutes. During the interviews, voice or video recordings were taken with the permission of the participants. Qualitative interviews were conducted by researchers GG and KÖ. Data analysis and content analysis of the records were done by other researchers GZ, DA, and EA. The interviews consisted of main and sub questions to understand how the occupational balance of the participants has changed during the pandemic. Semi-structured interview questions asked to the participants were as follows:

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

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

Q3: Have you started to perform new activities that you have not done before during the pandemic? If yes, what are these activities?

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

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

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

Q7: Have your job duties and responıibilities changed from before the pandemic? How did it change?

Data Analysis

Quantitive Data

Statistical analyses were performed using SPSS software version 24. The variables were investigated using visual (histograms, probability plots) and analytical (Kolmogorov–Simirnov/Shapiro–Wilk test) methods to determine whether they are normally distributed. Descriptive analyses were presented using medians and interquartile ranges (IQR) for the non-normally distributed and ordinal variables. Since the data such as occupational balance point were not normally distributed, nonparametric tests were conducted to compare these parameters. Working actively with COVID-19 patients were determined as a study group. Those without direct contact with the COVID-19 patient were separated as the control group. The Mann– Whitney U test was used to compare parameters between the groups (study group and control group).

Qualitative Data

We handled qualitative data according to standard phenomenological analysis procedures. Before the interviews were transcribed, all authors met to discuss the analysis plan. A writer (GZ) uploaded the written interviews to a Microsoft Word document and during the transcription of the interviews; Identities of all participants were removed to ensure confidentiality. Three of the co-authors (DA, KÖ, and EA) read the transcripts several times and identified specific expression categories. It was then gathered as a group to compare and contrast the statements. Each author independently completed a table listing separate categories for seven questions and noting important related statements and documenting ideas and possible themes. The main theme and sub-themes were determined by the authors with a joint decision. The categories with few expressions were merged with other categories or removed, while categories associated with multiple key expressions were preserved. The

remaining conspicuous categories, with their associated basic expressions, were reread and clustered. Details on the resulting themes are summarised in Appendix 1.

Results

Results

Participant Profile

Participants consisted of the study group (SG), which consisted of healthcare professionals working actively (n=105) and the control group (CG), which consisted of healthcare professionals not working actively in the Covid-19 pandemic (n=101). As depicted in Table 1, SG included 78 (74.3) female and 27 (25.7) male 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 with mean age 31.8 (SD=6.2) years. No significant differences were found between the groups regarding age, gender, marital status and caregiver role ($p>0.05$). The participants' demographic characteristics are presented in Table 1.

INSERT TABLE 1

Healthcare professionals' working conditions

As depicted in Table 2, working time pandemic in healthcare professionals was 6.6 (SD=2.9) month. Findings about healthcare professionals working conditions are presented in Table 2. When the participants' vocations were analyzed, it was found that nurses constituted the largest group in the SG, while other healthcare professionals constituted the largest group in the CG. Distribution of all vocations within the SG and CG is in Figure 1.

INSERT FIGURE 1

Healthcare professionals' occupational balance

The mean score of total occupational balance in SG was 9.2 (SD=5.2) and CG was 11.5 (SD=5.8). The occupational balance of the healthcare professionals with SG were found to be significantly weaker than healthcare professionals with CG ($p=0.005$) (Table 2).

When the occupational balance of healthcare professionals was examined based on the amount of breaks the individuals have, it was found that individuals who did not have enough brakes had a significantly weaker occupational balance ($p<0.001$) (Table 2).

INSERT TABLE 2

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 categories: self care activities, productivity activities, recreational activities, personal factors, environmental factors. The findings are supported by quotes from the interviews and labelled with Roman numerals. Qualitative findings on occupational balance are presented in Appendix 1.

Self care activities

Most of the participants did not state that their self-care activities changed during the pandemic period. Problems in self-care activities due to sleep deprivation, depression, stress, tiredness etc. reasons. Self care activities included personal care (feeding, sleeping), functional mobility (transfers, indoor, outdoor) or community management (shopping).

"My daily routine is to go to work and eat on the days I work. When I'm not working, I usually sleep. Sleeplessness becomes quite a problem during heavy work (Participation 95)".

"I can't care for myself sufficiently due to a depressed mood due to the COVID infection transmitted from the hospital, as well as sleep disorders and psychological problems (Participation 18)".

Productivity activities

The majority of the participants stated that the reason for the deterioration in occupational balance was the "increase in workload". Also, participants stated that they had difficulties doing household management. Carrying out their own and their children's educational

activities were problematic. However, the time spent in work-related activities, on the contrary, increased.

"*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 agree less. I don't feel like doing it (Participation 36)".*

Recreational activities

The majority of the participants stated that they had difficulties in social activities. 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 theater.

"I can't see my family. My social activities are completely over (Participation 38)".

"Before the pandemic, I used to gym regularly every day, now I almost never do it (Participation 67)".

Personal factors

The majority 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 loved ones.

"Our life 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 a disease (Participation 84)".

Environmental factors

Participants stated that their activities were negatively affected by the risky business environment and the long time they spent in the workplace. Also, the majority of the

participants stated that their social activities were negatively affected by the measures / restrictions taken by the state due to the pandemic.

"Working hard, working with a mask and special clothes is extremely tiring, your head is full of fear. The enormous stress is already exhausting your soul, heart and body. With these factors, even taking a bath can be impossible, which occupations can be done in a balanced way (Participation 58)".

Discussion

The main finding of this study was that the occupational balance of healthcare professionals who took an active role in the pandemic response was negatively affected. During the pandemic, most of the healthcare professionals have faced problems such as heavy workload, insomnia, depression, stress and fatigue. Factors such as exposure to risk, fear of infecting their loved ones and families, lack of protective equipment (Lai et al., 2020), physical fatigue in long-term use of protective equipment, limited resources (Çankaya, 2020), 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 in China found that healthcare profesionnels who are directly involved in the diagnosis, treatment, and care of patients with COVID-19 are at risk for developing psychological problems and symptoms related to mental health (Lai et al., 2020). In the study by Çankaya et al. (2020) it was found that the well-being of healthcare professionals during the pandemic was worse than before the pandemic. Significant differences were also observed in sub-items affecting, well-being such as depression, anxiety, physical and mental energy, and positivity. Similarly, our findings show that the occupational balance of healthcare professionals who take an active role in the pandemic was lower than who did not take an active role. In addition, 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 that people most need and tend to do during the pandemic transition and adaptation process. These activities are; engaging activities (phone calls, online training, virtual chats), center-oriented activities (yoga, meditation, long walks), creative activities (drawing, writing, painting, singing), thought-provoking activities (contemplation, prayer, prayer, yoga, journaling) and contributory activities (including projects, reaching those in need). In our study, the participants expressed the activities they started to do frequently during the pandemic were as follows; housework (cleaning, cooking), passive recreation (watching television, reading books), domestic activities (handicraft, hobby) and productivity activities (work, study, online courses). Although healthcare profesionnals turned to new activities during the pandemic, their occupation and role balance decreased. 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 for these activities due to reasons such as insomnia, depression, stress and fatigue. Among the self-care activities, especially the most affected area was sleep. In the study by Silva & Neto (2020), it was found that one of the most common problems experienced by healthcare professionals is insomnia and that insomnia is a risk factor for anxiety and depression. In our study, the participants expressed this issue as follows:

"I can't care for myself sufficiently due to a depressed mood due to the COVID-19 infection transmitted from the hospital, as well as sleep disorders and psychological problems".

The study by Shoja et al. (2020), showed that the total workload of healthcare professionals who took an active role in a pandemic was significantly worse than other employees. However, the increase in the working hours of healthcare professionals is one of the important factors affecting anxiety levels (Nakata et al., 2012). Similarly, healthcare professionals stated

that their workload increased, the time spent on work activities increased, they had to work on weekends, night shifts, increased responsibilities, professional burnout, occupational atrophy, and unprofessional duties. In particular, they stated that the change in work-profession descriptions was the most influential factor on productivity activities.

"I work more like a statistician, nurse, secretary and quality unit worker than an occupational therapist. We are serving 2 people with a nurse in the community mental health centre where we work 8 people. The workload has increased, I cannot focus on a single job".

Håkansson et al. (2020), emphasised that satisfaction level and balance in work, productive and leisure activities affect life satisfaction of the person, 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, that they could not see their loved ones for a long time, and that they mostly turned to online interviews. In addition, leisure time activities focus on passive activities such as reading books and watching television. Leisure 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 for ensuring the occupational balance of healthcare professionals and should be implemented routinely. Healthcare professionals working actively in the COVID-19 service; there was work-family conflict, difficulties in how to manage due to changes in the workforce, and conflicts arising from not being able to fulfil the roles fully (Baki & Piyal, 2020). Similarly, our findings showed that healthcare professionals have difficulties maintaining occupation-role balance. Most of them have changed in their parental, family, social and professional roles compared to before the pandemic. They spend less time with their family and relatives due to reasons such as infection anxiety, 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 in the role of parents stated that the time they spend with their children increased during the day and they were able to devote more time to housework due to the flexible work of healthcare professionals and the online education of 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 in this process.

Conclusion and clinical implications

In the COVID-19 pandemic, the occupational balance of healthcare professionals, are working with great devotion, has been significantly affected. During this process, 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 workload, healthcare profesionals devote most of their time to productivity activities. Quality leisure time activities cannot be done due to fatigue and psychological exhaustion in the remaining time from work. In addition, with the restriction of outdoor activities and the increase of activities in the home, leisure time activities have gained a unidimensional direction and the effect of this situation on the satisfaction of healthcare professionals and quality of life is a matter of discussion.

Limitations and future recommendations

The study had some limitations, because of both pandemic conditions and the busy working pace of the participants, interviews were conducted online. Face-to-face interviews could increase the contribution of the participants to the qualitative interview. Another limitation was that the distribution of the participants by profession groups 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, support and counselling can be provided by occupational therapists to support healthcare professionals whose occupation-role balance disturbed.

Key Points for Occupational Therapy

- In the COVID-19 outbreak, the occupational balance of healthcare professionals has been significantly affected.
- Recreational activities, participation in leisure activities that are valuable for the person are limited.

Data availability

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

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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	0.214
	Frequency (%)		Frequency (%)			
Gender						
Famale	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)			

M(SD): Mean and standard deviation

Table 2. Findings related to working conditions and occupational balance.

	Study Group (n=105)		Control Group (n=101)			
	Range	M (SD)	Range	M (SD)	Z	*P*-value
Working Experience (Year)	1-27	7.7 (6.9)	1-30	8.4 (8.4)	-1.435	0.151
Working time weekly (hour)	8-96	48.3 (14)	1-96	38.5 (14.8)	-0.237	0.813
Working time pandemic (month)	1-10	6.6 (2.9)	-	-		
OBQ11-T Total	1-23	9.2 (5.2)	1-24	11.5 (5.8)	-2.781	**0.005***
	Enough break (Yes) (n=102)		Enough break (No) (n=104)			
OBQ11-T Total	2-24	12.4 (6.2)	1-23	8.2 (4.8)	-5.004	**<0.001****

*p<0.01; **p<0.001; M(SD): Mean and standard deviation

Appendix 1. Qualitative findings on occupational balance (N=171).

Q1: *What are your routine activities in your daily life? When the pandemic started, which of these daily life activities did you have difficulties in performing?*			
Performance Areas	**Before Pandemic**	**How to define during the pandemic?**	**Participant Statements with the Theme Highlighted in Bold**
Self Care Activities	• Personal Care (F*eeding, sleeping*) • Functional Mobility (*Transfers, indoor, outdoor*) • Community Management (*Shopping*)	Most of the participants did not state that their self-care activities changed during the pandemic period. It was stated that "***sleeping*** "the most affected in self-care activities.	"My daily routine is to go to work and eat on the days I work. When I am not working, I **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 difficulties doing Household Management Conducting their own and their children's educational activities was problem However, the time spent in business activities, in contrast, increased.	**"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, travel, going cinema/theatre) • Socialisation (Meeting friends)	Most of the participants stated that they had difficulties in social activities	"I cannot go to **sports**, I cannot go out, I cannot **see my friends**, I cannot **take my baby outside** "

		It was stated that among the recreational activities, the most restricted areas are • Doing sports • Spending time with friends or family • Going to the cinema / cafe / theatere • Outdoor activities	"I can't see my family. My **social** activities are completely over". "Before the pandemic, I used to **gym** regularly every day, now I 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 living activities?*			
	Factors thought to have a negative impact		**Participant Statements with the Theme Highlighted in Bold**
Personal Factors	Most participants stated that their activity participation and range of activities were negatively affected, as they feared carrying the disease to their family or loved ones		"Our life between hospital and home has increased even more due to COVID-19 for 8 months. Since I am a healthcare proffesionel, I unwittingly avoided many activities in order not to be in crowded environments in society and **not to infect others** if I have a disease".
Environmental Factors	***Physical environment:*** Participants stated that their activities were negatively affected by the risky business environment and the long time they spent in the workplace ***Institutional environment***: Most participants stated that their social activities were negatively affected by the measures/restrictions taken by the state due to the pandemic		"**Working hard**, **working with a mask or special clothes** is extremely trying, your head is full of fear. The enormous stress is exhausting your soul, heart and body. With these factors, even taking a bath can be impossible, which activity can be done in balance ?!" "Many places are **closed** due to the pandemic, public events are **forbidden**, and even going out is **prohibited".**

Q3: *Have you started to perform new activities that you have not done before during the pandemic? If yes, what are these activities?*

Activities	**Frequently stated themes**	**How to define during the pandemic?**	**Participant Statements with the Theme Highlighted in Bold**
Not Doing New Activities	• Fatigue • Lack of motivation	Most participants stated that they did nothing new. They reported that the reason for this was fatigue and lack of motivation.	"I 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 spend more time on activities performed at home. (Craft, hobby, cooking, watching movies, reading books, yoga, pilates…) Participants reported innovations in productivity activities such as taking online courses.	"I started to spend more time **in the kitchen**. I started making new dessert and pastry recipes ". "We learnt to spend more time **at home**". "During the quarantine, I could **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 (F*eeding, sleeping*) • Functional Mobility (*Transfers, indoor, outdoor*) • Community Management (*Shopping*)	Most of the participants state that their occupational balance changed during the pandemic period. It was stated that "self-care activities" was the most affected occupations Problems in self-care activities due to sleep deprivation, depression, stress, tiredness etc. reasons.	"I am physically exhausted and can't rest. I can't **sleep**. That is why I can't do my **self-care activities** enough". "I **can't care for myself sufficiently** due to a **depressed mood** due to the COVID-19 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)	Most of the participants stated that the reason for the deterioration in occupational balance is the "increase in workload"	"I think it's broken. The **workload** is **heavy**. Because we have been **working at the same pace for a long time**. I feel tyred both physically and psychologically. This situation affects the participation in my activities and therefore I agree less. I do not feel like doing it. " "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, watching TV/ movie) • Active Recreation (Sports, travel, going cinema/theatre) • Socialization (Meeting with friends)	It is seen that the participants prefer "quiet recreational activities" (reading books, watching TV series / movies) after the pandemic	"I can no longer meet my friends outside. I **read a book** or watch TV at home." "Yes, it is broken, I **can't exercise** with a mask." "My occupational balance is disturbed because we **can't meet with our friends.** We can't 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	• Paid Work • Household Management (Cleaning, laundry, cooking) • 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 **Household Management:** It was stated that "increased fatigue in work life" was affected the most in household management. **School: "**Flexible working hours" appear to make it easier to balance school work	"I work more like a statistician, nurse, secretary and quality unit worker than an occupational therapist. We are serving 2 people with a nurse in service where we work 8 people. The **workload has increased**, I cannot focus on a single job. " "The pandemic caused me to try managing work-related situations at home, outside working hours. It has become **difficult for me to do housework**. " "My working life hours have decreased. Starting to do my **online lesson**s and work

			together enabled me to do **better time management** "

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

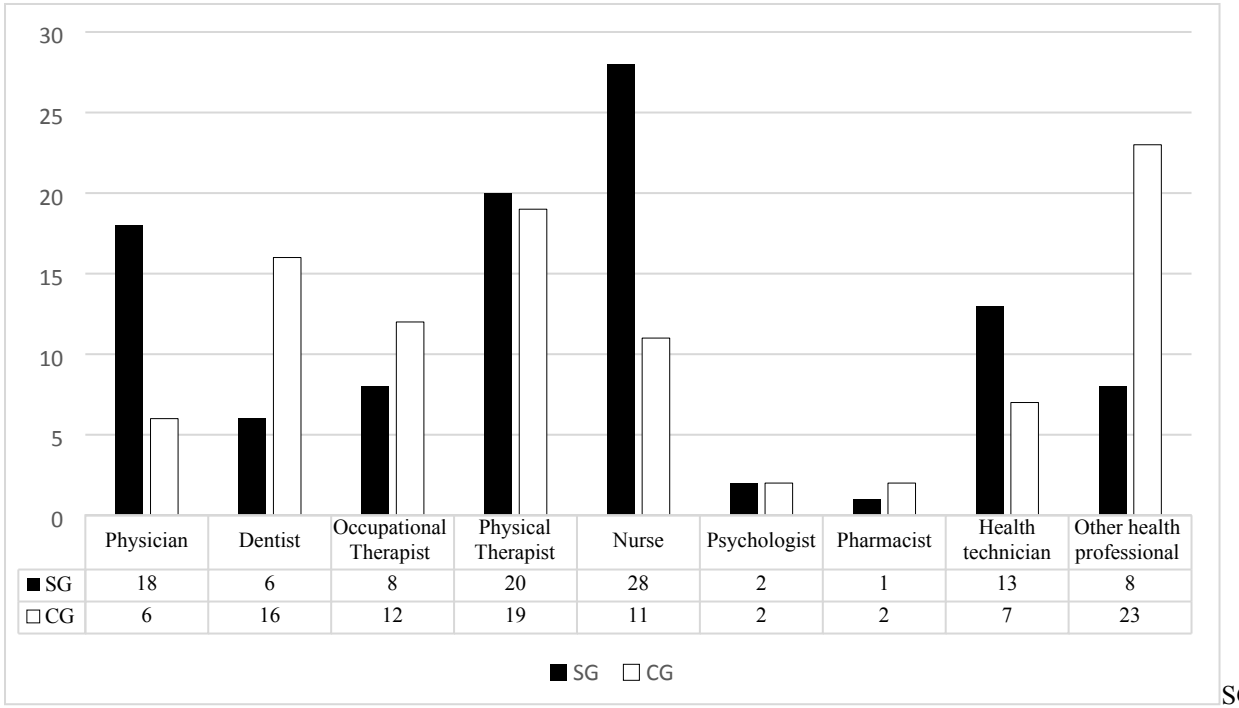
Roles everyday life	**Before Pandemic**	**Were any changes in your roles in the pandemia?**	**How did that change? How did this situation affect you?**	**Participant Statements with the Theme Highlighted in Bold**
Parenting Roles	• Mom • Dad	Yes	**1. Emotional Effect** Stress Sad Fear Boredom Uneasy More pensioner Angry Introversion Fear of transmitting a disease to the parent **2. Difficulty in time management** Spending less time with our	''Since I cannot come home rested, I cannot fulfil my duties towards my 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 1, I cannot help him with his homework because I come home **tired** in the evening.''
Family Roles	• Child • Sister • Brother • Wife	Yes		''As a child, I became more **angry and intolerant**, which was caused by spending too much time with my family.''

Professional Roles	• Doctor • Occupational therapy • Nurse • Health employer • Social worker	Yes	family, children and loved ones 3. **Challenge with Role-Activity Balance** 4. **Physical Effect** Tiredness No rest 5. **Lifestyle Changes** 6. **Impacted by the work load** Inefficiency Professional Blinding 7. **Positive Changes in Roles** More time for home work Better a child	''I **do not have a therapist role** anymore, I work actively in the field with COVID-19. It is sad to stay away from the field of therapy that will apply my theoretical knowledge and practise.''
Social Roles	• Friend • Roommate • Boy-girl friend	Yes		''We could not meet my lover during quarantine. This caused unnecessary quarrels between us.''

Q7: *Have your job duties and responibilities changed from before the pandemic? How did it change?*

Changes in work	**Sub Themes**	**Participant Statements with the Theme Highlighted in Bold**
Reducing Responsibilities	• Transition to flexible work	''We switched to flexible working. Certain days of the week we **only go to work**.''
Increase in Responsibilities	• Increase in the number of working days and overtime hours • Increase in treatment time for patients • Increase in more intensive work due to the large work load • Increase in physical fatigue	''I was working 8 h a day before the pandemic. However, now I **work 16 hours a day**. Our mission COVID-19 is in direct contact. More stressful, fear of getting sick.''

Change in Occupational and Professional Concept	• Working at the weekend • Night shift • Increase in professional burnout • Loss of profession due to different handling • Adding non-professional assignments	‘’I am working more now than before the pandemic. While I was only doing my **own profession before the pandemic**, now I am working as a secretary outside my profession. I am professionally blunt.’’
Increase in More Careful and Ticket Work		‘’ COVID-19 patients had to be treated more carefully and meticulously, we **followed work hygiene rules more.**’’



SG: Study Group; CG: Control Group

Figure 1. Participant vocations in both groups.