This paper outlines the reflections and thought process I had in considering how occupational therapists can be leaders in mental health. Specifically, I drew on my own experience with mental illness as a starting point to identify a gap in mental health services. This led to the development of a type of intervention that is occupationally-focused and stems directly from the founding principles of occupational therapy. I hope that this paper will inspire others to recognize how important our contributions are, and how much individuals with depression would benefit from what we have to offer. Although mental health historically has been dominated by the fields of psychiatry, psychology and medicine, occupational therapists should assume a leadership role in this arena, because our contribution is equally as important.

Depression is a debilitating mental illness. I know this firsthand. When I was 16, my parents realized that I was experiencing more than “typical teen angst” and took me to a psychiatrist to investigate my feelings of anger, lethargy, apathy, and hopelessness. Within the first 15 minutes of my appointment, I was diagnosed with depression and given a prescription for anti-depressants. I also attended upon a social worker for weekly therapy sessions, where I usually lied when asked how I was doing and downplayed my true feelings for the sake of not making my therapist (and myself) uncomfortable and telling her what I thought she wanted to hear. The medication helped, but the dosage kept having to be increased every few months because I would become tolerant to its effects and relapse in to a depressed mood. By the time I was 21, I was on a dosage that was three times the recommended strength for someone my weight. I discovered this after asking my pharmacist whether I’d ever find a dosage that would properly manage my depression.

“You’re taking these for depression?” my pharmacist asked, looking at me in surprise.

“Yes. They’re anti-depressants,” I replied, trying not to sound rude as I stated the obvious.
He looked at slightly bewildered and shook his head. “These technically are anti-depressants, but they haven’t been used for depression since the 1970s. They’re prescribed as a sedative nowadays. I thought you were having sleeping problems.”

I was stunned. Then angry. My psychiatrist either stopped listening after I told him I was having difficulty with my sleeping patterns, or he had not been informed of pharmaceutical advances in over 30 years. Most frustrating of all, however, was that I now felt hopeless about ever managing my depression. Five years of being on medication and attending therapy had done little to help me feel like I was in control of my illness.

Luckily, over the next couple of years, I was able to find a therapist I felt comfortable opening up to, as well as a medication that actually managed my symptoms. Despite being committed to these interventions, from time to time a stressful event would trigger a bout of depression that I felt unable to pull myself out of until the feelings simply went away. During these low points, I would spend more hours sleeping than awake, skip class, let my dirty clothes pile up until my laundry bin overflowed, and shun my family and friends. I would go two or three days at a time without showering or eating, simply for the fact that I couldn’t be bothered to get out of bed and prepare myself to interact with the world. I lost all interest in watching my favourite television shows, working out, and even shopping – an activity I almost never passed up. I lacked the motivation and the will to do anything but sleep, even though rationally I knew that I would probably feel better if I spent even an hour doing something other than lying in bed and thinking.

Reflecting on these dark times in my life, it’s clear that I displayed a number of the “classic” symptoms of major depressive disorder:

- “markedly diminished interest or pleasure in all, or almost all, activities;
- fatigue or loss of energy;
• insomnia or hypersomnia;
• significant weight loss when not dieting ... or decrease or increase in appetite;
• feelings of worthlessness;” (American Psychological Association [APA], 1994).

In addition to these symptoms, or perhaps because of them, I clearly met the fourth criteria for being diagnosed with clinical depression: “The symptoms cause clinically significant distress or impairment in social, occupational, or other areas of functioning” (APA, 1994). To say my functioning was disrupted during these times is to put it lightly.

To frame my experience through an occupational lens, I was demonstrating occupational disruption as a result of my depressive episodes. I was no longer performing my basic or instrumental activities of daily living, had stopped fulfilling my role as a student, and could not find the motivation to participate in the leisure activities I genuinely enjoyed. My occupational balance was seriously off, considering I would spend anywhere from 12-18 hours a day asleep. I had stopped engaging in essentially all my occupations, and fuelling my feelings of a lack of control over my illness, I believed I was already doing all I could to manage my symptoms through pharmaceuticals and psychotherapy, and would have to accept that this was just something I had to deal with as a result of having depression.

A combination of pharmaceutical and psychotherapy interventions is the most common treatment for depression (National Institute of Mental Health [NIMH], 2009), and literature on the efficacy of other forms of treatment is scarce. However, although these interventions may dominate, there are instances when they are clearly not enough, as was my experience. Consistent with one of the hallmark symptoms of depression, my functioning was severely impacted and I needed help re-engaging in my occupations and finding meaning in them. My anti-depressants and weekly therapy
sessions were not assisting me in this problem. This is a gap I believe occupational therapists are well positioned to fill.

Occupational therapists have at their disposal a unique understanding of the importance of having meaningful activities to occupy one’s time. Almost a century ago, the psychiatrist Dr. William Rush Dunton (who helped to found what we know today as the American Occupational Therapy Association) created the Credo for Occupational Therapists (1919) which stated that humans need occupation, and occupation has therapeutic potential (Dunton, 1919). Additionally, Dunton established that:

- Occupation is as necessary to life as food and drink;
- Every human being should have both physical and mental occupations;
- All should have occupations which they enjoy, or hobbies;
- Sick minds, sick bodies and sick souls may be healed through occupation (Dunton, 1919).

These are the principles by which occupational therapists continue to operate with today. Further, we believe that occupations are a determinant of health and well-being, a source of meaning and purpose, and a means of organizing time (Law, Polatajko, Baptiste & Townsend, 1997). Not having the ability to engage in meaningful occupations has even been said to have such a debilitating impact that it results in death (Polatajko, 1992).

These guiding principles and beliefs are the reason that using an occupational approach to treating depression makes sense - because it directly addresses the lack of participation and functional disruption many clients with depression experience. I strongly believe that occupational therapists need to assume a leadership role in the treatment of depression. The foundation on which our profession lies is exactly the paradigm that is needed to address many of the symptoms of
depression, and can be applied in practice to help individuals who have depression re-engage with their lives.

Currently, occupational therapists working with clients with depression tend to utilize a psychosocial approach. Treatments may consist of, or include, cognitive behavioural therapy, mindfulness meditation techniques, family interventions, or psychotherapy. While these approaches are valuable, I feel that occupational therapists should utilize an approach that includes what we know best: occupations. This stance is reflected in an article written by Ashley Opp Hoffman, an occupational therapist and the American Occupational Therapy Association’s senior staff writer. Hoffman writes that “although medication can be an important component of treating depression, occupational therapy practitioners can help those with depression to restructure their daily lives, find meaning in daily occupations, and redefine their sense of identity” (Opp Hoffman, 2007). She suggests that by helping clients examine meaningful life roles and associated responsibilities, it can then be determined the factors that interfere with a person’s ability to meet these responsibilities. In identifying barriers to participation in occupations, a plan can be made to adapt responsibilities and deal with challenges, which “ensures that clients follow through on things, so that they meet the responsibilities of the roles that are meaningful to them” (Opp Hoffman, 2007).

To draw on an experience familiar to us all, the pain of a broken heart can leave even the strongest of us feeling devastated. This often translates in to long hours sleeping, calling in sick to get out of obligations, and turning down invitations and opportunities to socialize. Choosing to wallow in our grief, we too often ignore the advice of family and friends who encourage us to get out of the house, keep ourselves busy, or simply do something. When we finally find the strength to start participating in our day-to-day activities again, we often find that our feelings of sadness are replaced with a sense of enjoyment, accomplishment, or renewed hope. We can apply our own experience to help our clients, and help them see the value in staying involved in their meaningful roles and
occupations. This also supports the notion that in the practice of occupational therapy, occupations are used as a means and as an end: we use occupations as a therapeutic medium with the end goal of helping our clients engage in their chosen occupations.

From here, I outline an intervention that occupational therapists could utilize in the treatment of depression, created based on my personal experience and the argument that occupational therapists should play a key role in the treatment of depression. The intervention I have proposed combines motivational interviewing, patient education, and self-guided discovery.

**Step 1.** Impart the importance of “doing”, and how participating in meaningful roles and occupations in turn provides a sense of purpose, well-being, and satisfaction in life.

*Suggestion of what to say:* “One of the difficulties that people who have depression encounter is feeling motivated to do things. They might stop taking care of themselves, keeping in touch with family and friends, or going to work. It can really be helpful to have things to do – especially things that are meaningful and important to you – to help you get through the day. Often times, even though you may have to force yourself to go out or accept an invitation, you’ll feel a lot better after, and hopefully it’ll motivate you to keep participating in that activity!”

**Step 2.** Help client identify meaningful roles and occupations

*Suggestion of what to say:* “I know right now you may be finding it difficult to feel motivated to do all the things you used to do, or want to be able to do. The first step we’ll take is to think about the roles and activities that you find meaningful / are important to you / you want to be able to take up again.”
Step 3. Identify associated responsibilities, tasks, or indicators of participating in the identified roles and occupations.

*Suggestion of what to say:* “With regards to your role as XX your desire to re-engage in XX, what are the things you do to maintain this role?” (e.g. Role as a student involves attending class, printing lecture notes, group meetings, writing assignments, studying for tests, reading textbooks)

*Suggestion of what to say:* “With regards to your desire to re-engage in XX, what did you used to do to stay involved?” (e.g. Participating in sports team may have involved phoning teammates to co-ordinate games, socializing with teammates, practicing individually or with a friend, maintaining fitness levels by exercising, viewing media related to the sport)

Step 4. Identify barriers to participating in roles and occupations.

*Suggestion of what to say:* “Even though you’ve identified XX as being an important part of your life, it sounds like you haven’t been participating in XX as often or as much as you used to and would like to. What do you think is preventing you from doing this?”

Step 5. Collaborate with the client to develop concrete strategies he or she can use when encountered with the identified barriers.

*Example:* Client says when he is feeling depressed, it takes too much energy to think of things to do. Solution could be to create and post a list of meaningful activities, including some that do not require money or equipment, that he can refer to when needed.
Example: Client says she feels overwhelmed with the things she has to do and so she chooses instead to do nothing. Solution could be to create a weekly schedule that balances her responsibilities and her interests so she fulfills her obligations but also finds time for enjoyment.

A self-assessment that can be used to assess change is the Occupational Questionnaire (OQ) (Smith, Kielhofner & Watts, 1986). This assessment consists of a time diary that requires the client to record the primary occupation he/she was participating in every half hour of the day. Additionally, for each activity listed, the client must indicate the type of occupation, and their perception of its performance, importance, and enjoyment. Although this is a descriptive assessment, it could be administered before and after the intervention to identify changes in both the type and frequency of the occupations the client participates in. Additionally, it would be useful for the client to complete the OQ prior to the intervention as it provides a visual representation of their day-to-day activities, and may emphasize the occupational imbalance the client is experiencing. Filling out the OQ at the end of the intervention, when the client has re-engaged in meaningful occupations he or she enjoys, will hopefully serve as positive reinforcement for participating in those occupations even though at first it may not seem appealing.

This intervention can be done in any setting and with clients of any age or severity of depression. As previously mentioned, standard treatment for depression consists of a combination of anti-depressant medication and psychotherapy. These interventions are valuable, and rather than advocate for occupational therapy to take a centre stage in the treatment of depression, I suggest that we work alongside the other “major players” (e.g. psychiatrists, psychologists, psychotherapists, etc.) to collaboratively develop a comprehensive approach that gives individuals with depression the best possible chance of managing their symptoms. Therefore, this intervention should be considered one part of a multi-faceted treatment approach. While pharmaceuticals can help relieve some of the symptoms of depression, and psychotherapy can help relieve distressing feelings,
occupational therapy can help clients find meaning and purpose through “doing”, thereby contributing to a sense of well-being and satisfaction with one’s life. In congruence with recovery principles, occupational therapists can also help clients by giving them tools to help themselves, enhancing a sense of self-efficacy and control. Occupational therapists should advocate to other health professionals, especially those who have a strong presence in the treatment of depression, for the unique role and value we can bring to this area, and make it known that what we have to offer is just as important as conventional treatment methods.

To summarise the position I have put forwards in this paper, I believe that the treatment of depression could be greatly improved by the addition of an occupational therapy intervention. Although we are recognized as practitioners in mental health, the interventions we utilize are not specific to our profession and were not developed using an understanding of occupation. Further, we are often a secondary referral and not one of the “key players”. I believe this needs to change, and we must establish ourselves as leaders in the treatment of depression. We do not need to draw on principles from other professions, and need to look no further than to the most basic principles our profession was built on, indicating how well-positioned we are to help individuals who have depression. It is not easy to elicit change, and to have our voice heard and see occupational therapists be recognized as leaders in mental health, we will need to advocate strongly for our profession. I believe that the value we can have in serving those with depression is too great to not have our voices heard.
References


Appendix A

A. Reflect on a time you chose to do “nothing”, despite having responsibilities, obligations, or enjoyable activities at your disposal. Perhaps you were fuelled by feeling sad following the end of a relationship, or felt you simply could not muster the mental energy required to finish writing that paper.
   a. Did you feel frustrated with your lack of motivation and participation in your occupations? Was there a part of you that knew you would feel better if you just forced yourself to do something?
   b. When you pulled yourself out of this “funk”, did you find that your negative feelings quickly dissipated, or were at least temporarily gone?

B. The next time a friend, family member, or even a client expresses an inability to participate in their meaningful occupations, expand on the age-old wisdom of “just do something!” by encouraging them to reflect on the sense of enjoyment and satisfaction they obtained from engaging in their occupations. Instill a sense of hope by reassuring them that they can find happiness and purpose through important and enjoyable activities.

C. Brainstorm how you can take a new approach to the treatment of depression by utilizing a more occupationally-focused intervention, such as the one suggested in this paper. How would you explain to other healthcare professionals the rationale behind using this new approach, as opposed to engaging the client on mindfulness meditation techniques or other strategies we have historically relied on? How might you monitor and evaluate the effectiveness of your approach?