# Activities and Adaptation in Late-Life Depression: A Qualitative Study

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MeSH TERMS
- activities of daily living
- adaptation, psychological
- choice behavior
- depressive disorder
- motivation
- qualitative research

OBJECTIVE. We sought to understand activity choices of older adults when they were depressed.

METHOD. Each community-dwelling participant ($n = 27$) completed one semistructured interview while in recovery for at least 3 mo. but less than 7 mo. Transcripts were coded to identify relevant themes.

RESULTS. Six themes emerged that explained activities participants continued while depressed, and four themes described activities they stopped.

CONCLUSION. Older adults maintained many instrumental activities of daily living while depressed, and some actively adapted activities so they could continue them. Some intentionally stopped activities to direct limited energy to their highest priority activities. To guide effective intervention, it is critical for occupational therapy practitioners to complete a client-centered qualitative assessment to understand what and, most important, why activities are continued or stopped. Each theme for activities continued and activities stopped lends itself to intervention strategies.

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Functional disability, which includes activity limitations and participation restrictions, is a cardinal symptom of major depression. *Depression* is "clinically significant distress or impairment in social, occupational, or other important areas of function" (American Psychiatric Association, 2013, p. 161). *Major depression* is characterized by a change in mood or sleeping or eating habits, low energy or fatigue, reduced concentration, feelings of worthlessness or excessive guilt, psychomotor agitation or retardation, or thoughts of death or suicide (American Psychiatric Association, 2013). Major depression may be a primary diagnosis, or it may exist comorbidly with medical conditions such as cardiac disease (Dickens, Cherrington, & McGowan, 2012) or stroke (Ayerbe, Ayis, Crichton, Wolfe, & Rudd, 2013). Moreover, major depression is associated with stress, medications prescribed for other conditions, and severe and traumatic life events such as the death of a spouse or poverty (Institute of Medicine, 1994). The prevalence of major depression in older adults is 1%, and an additional 15% have depressive symptoms that do not meet full diagnostic criteria (Alexopoulous, 2005). Because the number of older adults is projected to increase to 82 million in the United States by 2050, the number experiencing depression will likely increase, adding to existing public health concerns (Jarvik & Small, 2005). Depression renders negative consequences not only for the individual but also for society and the health care system. It is associated with greater health care costs, increased medical burden, and longer hospital stays (Luber et al., 2000).

The association between depression and disability has been demonstrated in many studies, as noted in Lenze and colleagues' (2001) systematic review. In most studies, however, authors examined activity domains rather than activities. Thus, they reported on limitations in basic activities of daily living (ADLs) and instrumental ADLs (IADLs) in the aggregate, revealing little about engagement in individual activities (Grigsby, Kaye, Baxter, Shetterly, & Hamman, 1998; Ormel et al., 1998). No researchers have examined the dynamics of activity engagement as clients react and adapt to the effects of a depressive episode. Thus, little is known about clients' perspectives on the functional consequences of depression.

As experts in ADLs and IADLs, occupational therapy practitioners are uniquely qualified to address the habits and skills clients need to support participation in meaningful daily activities (Rogers & Holm, 2000). Without an understanding of clients' perspectives on how depression affects their daily life activities, practitioners lack the contextual perspective necessary to assess clients with depression and determine interventions that will be most effective for supporting everyday activities and functioning (Lang, Rieckmann, & Baltes, 2002). To provide insight into the dynamics of activity engagement, this descriptive study examined daily life activities of older adults during a depressive episode using an interactive qualitative assessment method (Sandelowski, 2000).

## Method

### Participants

Participants were recruited from a randomized clinical trial (RCT; P30 MH090330, R01 MH043832, UL1 TR000005) investigating the combined effect of an antidepressant and donepezil on cognitive and functional performance. Inclusion criteria were age ≥65 yr; diagnosis of nonpsychotic, nonbipolar major depression documented on the Structured Clinical Interview for *DSM–IV* Axis I Disorders (First, Spitzer, Gibbon, & Williams, 1996) and with a rating of 15 on the 17-item Hamilton Depression Rating Scale (HDRS; Hamilton, 1960); ability to speak English; willingness to discontinue psychotropic medications other than study medications; presence of an available informant willing to corroborate information; and hearing capacity adequate to respond to raised conversational voice. Exclusion criteria included diagnosis of dementia based on criteria of the *Diagnostic and Statistical Manual of Mental Disorders* (4th edition; American Psychiatric Association, 1994); bipolar disorder, schizophrenia, or schizoaffective or other psychotic disorder; or alcohol or other drug abuse within the past 12 mo. For our study, participants also had to be in the recovery phase of depression for ≥3 mo but <7 mo. *Recovery* was defined as an HDRS score of ≤10 for 3 consecutive weeks.

### Data Collection

Although our concern was activity engagement when depressed, research and clinical experience indicate that when people are depressed, they are less verbal and may lack insight (Edison & Adams, 1992). Thus, we interviewed participants 3 to 7 mo after their depression had stabilized. This amount of time was seen by experts in late-life depression as sufficiently close to the depressive episode for participants to recall it yet distance themselves from it enough to talk about it.

After University of Pittsburgh institutional review board approval, consecutively enrolled participants in the RCT were recruited by their primary practitioner. The principal investigator (PI), Mary Lou Leibold, telephoned participants to schedule an interview. Written informed consent was obtained. The PI conducted semistructured qualitative interviews approximately 2 hr long in a private venue convenient to the participant. Interviews were audiotaped and transcribed verbatim, the PI verified transcription accuracy, and participants' illness information was obtained from RCT records.

During the interview, we used the Activity Card Sort (ACS; Baum & Edwards, 2001) as a stimulus for discussion. The ACS was developed to measure engagement in activities and monitor activity participation over time using a quantitative approach. This version of the ACS consists of 80 color photographs of culturally diverse older adults engaging in activities in four domains: (1) instrumental (e.g., laundry), (2) low-demand leisure (e.g., photography), (3) high-demand leisure (e.g., swimming), and (4) social (e.g., traveling). We selected the ACS because it would assist in promoting recall, prompting conversation, providing structure and focus during the interview, and supporting consistency among interviews.

Participants reviewed the activity cards and discarded those depicting activities they had not routinely done in the past 2 yr. They indicated whether an activity was continued or stopped when they were depressed. For each activity continued, the PI asked, "Can you help me to understand what it is about this activity that influenced you to keep doing it?" and "Now I'd like to know if you did the activity the way you usually did it when you were not depressed or if you did it differently in some way." The PI used additional probing questions, such as, "Can

you tell me more about this?" to clarify responses and confirm understanding. The open-ended nature of the questions and individualized probes facilitated rich and detailed narratives. A similar procedure was used to inquire about activities stopped.

### Data Analysis

The PI reviewed each interview and documented intuitive feelings regarding the participant's experience that emerged through words, facial expressions, and body language. All transcripts were entered verbatim into a software program, Atlas.ti (Version 5.2; ATLAS.ti Scientific Software Development GmbH, Berlin), and the PI coded them to identify activities continued and rationale, altered ways of continuing an activity, and activities stopped and rationale. Data for the three codes were analyzed by the research team. Patterns and themes emerged and were reshaped over time as additional participants revealed their experiences. Once all interviews were completed, the PI created an initial list of themes. Three members of the research team scrutinized these themes and made modifications until consensus was reached. Some participant responses fit into more than one theme, resulting in dialogue by the research team to attain consensus on the themes. Additionally, a peer debriefer coded four transcripts (15% of the data) using the themes.

We used several strategies to promote credibility. Skills in interviewing and data analysis were honed through a pilot study completed by the PI with 4 participants. Prolonged engagement with interviews of 2 hr duration allowed time for participants to become accustomed to the PI and interview process. Using the ACS to anchor interviews ensured consistency of activities addressed among participants and facilitated breadth and depth of responses. The cyclic nature of the interview permitted participants to rethink and change their responses throughout the interview and the PI to identify discrepancies in responses and probe for clarification. Additional members of the research team (experienced researchers and experts in late-life depression) critically appraised case examples identified as representative of each theme. Themes were not exclusive, and some case examples may have fit more than one theme, requiring review and consensus within the research team.

## Results

### Participant Characteristics

Twenty-nine participants met study criteria before closing admission to the RCT; of those, 2 declined to participate. Apprehension about reflecting on unpleasant times and lack of personal benefit were cited as reasons for refusal. The remaining 27 participants had a mean age of 73.3 yr (range = 65–88) and mean educational level of 14.6 yr (range = 10–19). Twenty were female (74%), and 12 (44%) were engaged in paid employment. The mean number of months since stabilization of depression was 5.17 (range = 3–7 mo). The mean HDRS score 1–2 wk before the interview was 4.7 (range = 0–10), indicating recovery from depression. All participants were community dwelling; 26 were White, and 1 was African American.

### Thematic Analysis: Activities Continued During Depression

Examination of participants' experiences revealed six themes elucidating their activity engagement:

1. Established habits and commitments kept me engaged.
2. Some activities were still gratifying.
3. Family and friends nudged me into action.
4. I gotta keep going.
5. Distraction and escape took me away from my situation.
6. I'm hiding my depression from other people.

#### *Established Habits and Commitments Kept Me Engaged.*

Participants retained activities that were part of a long-standing habit, including those required for survival and self-sufficiency such as cooking and laundry. Activity habits were established at different times throughout participants' lives and for different reasons; for example, the activity of dining at a restaurant monthly with friends stemmed from relationships established in college. This theme includes prearranged activities that incorporated a commitment forged by a financial expenditure, typically purchasing a theater or sporting event subscription. Moreover, participants retained activities that involved a designated time with accountability to other people.

Some participants independently adapted activities, enabling them to continue. For example, they altered methods to complete the activity more quickly, such as preparing stir fry meals rather than using the oven. Venues were changed to facilitate activity engagement, such as hosting an annual family gathering at a restaurant after a child's death to avoid the familiar home environment with an empty chair at the table. Finally, some people continued yet constricted activities by, for example, reading only the coupon section of the newspaper and discarding the remainder. This theme was reflected by participants in terms such as *it just becomes a habit, I did it all my life,* and *I have a subscription.* One gentleman continued to read the newspaper, stating,

> I'm a newspaper nut. . . . every morning . . . I buy that newspaper, and I read it. And I don't even think about it. . . . it's been going on for at least 50 years, more than that. I read it, . . . but I'm not sure I got anything out of it, you know, but I did read it.

*Some Activities Were Still Gratifying.* Despite being depressed, participants experienced pleasure or a sense of accomplishment when engaging in some activities. Pleasure was derived from the relaxation, stimulation, and positive feelings, whether current or reminiscent of the past, inherent in activity engagement. Interestingly, some people found activities that were physically taxing pleasurable, others craved a social connection with friends, and some identified the unconditional love of a pet as pleasurable. A sense of accomplishment was demonstrated, for example, by one participant who quilted a gift for a friend. Some participants made modifications, such as watching a movie at home to eliminate fatigue during travel. This theme was described by participants in terms such as *I love to do it, it makes me feel good,* and *it's a sense of accomplishment.* One woman continued gardening because it "made me feel better. It was . . . something manual, which became really important when I was depressed. I was more likely to do that than something that would involve talking, especially . . . socializing."

*Family and Friends Nudged Me Into Action.* Other people played a powerful role in prompting participants' activity engagement. Vigilant spouses, partners, children, neighbors, or friends provided the crutch needed to sustain activity when participants might not have been able to do so alone. Extending an invitation, initiating activity that required a response, providing transportation, making supplies available, and uniting efforts as a family were strategies used to encourage activity. For some participants, the joy of interaction with grandchildren, on request or to demonstrate family support, had a distinctive influence on activity engagement. This theme was expressed by participants in phrases such as *only if someone gave it to me, when I'm told to,* and *if they picked me up.* One gentleman told us, "This person that I'm seeing kept pushing me to find something to do, to get out of the house," which led him to volunteer work.

*I Gotta Keep Going.* This theme stresses participants' deliberate participation in activity. Participants emphasized their initiation of activity in either the typical or an adapted way, even when they were not interested, in hopes of preserving their lifestyles. Participants pushed themselves, aspiring to improve their mood, maintain financial security, retain friendships, avoid loss of decision-making power to a spouse, or avoid decreased joint mobility. In fact, some participants modified aspects of activities such as intentionally restricting interaction to friends with a positive influence or employing a financial advisor to manage investments. This theme was illustrated by participants in terms such as *I try to maintain a feeling of normalcy, I forced myself to do everything whether I wanted to or not,* and *it gave me some sense of control over what was going on in my life.* One woman never missed church, explaining,

> If you stop going to church, you're really disconnecting yourself from the things that are, for me anyway, the most important in my life. And if I stop going to church, . . . it's all downhill from there, because my social contacts are a big part of church.

*Distraction and Escape Took Me Away From My Situation.* Participants engaged in some activities to divert attention from themselves or negative circumstances. Two levels of disconnection emerged, distraction and escape. Distraction, a more superficial form of diverting attention, provided an avenue to redirect thinking through physical and sedentary activities. Some participants intentionally adjusted movie selections to those with a positive focus. Interestingly, one woman used a self-distraction technique of engaging in two tasks simultaneously to remain sufficiently engaged to avoid time for negative thinking. Escape, a deeper level of disconnection, gave participants a way to remove themselves from their current situation by temporarily entering a different environment. Methods of escape ranged from active to passive (e.g., rest). This theme was expressed by participants in phrases such as *I can kind of turn off my mind for a while, it kept me from thinking,* and *I did it to make me be somewhere else and feel different.* One woman watched movies at home, noting she could "forget about all . . . troubles. I can watch a corny old movie on television—those Hallmark and Lifetime movies that, you know, had a happy ending and . . . that make me feel pretty good."

*I'm Hiding My Depression From Other People.* Some participants attempted to hide their depression from others by maintaining previous activities in order to avoid upsetting them, prevent further unwanted caregiver assistance, and evade the stigma associated with depression. For example, grocery shopping was retained because it fulfilled household responsibilities, and beauty shop services were continued to keep up physical appearances. Participants proactively altered methods to complete some activities more expeditiously, for example, by grocery shopping in a single store. Phrases participants used to express this theme were *I did not want to tell them I was*

*depressed, I didn't want my wife to realize how bad I was feeling and she's used to me doing that,* and *I tried to act natural.* One mother continued hosting Sunday dinners, recalling,

> I didn't want to tell them I was depressed because then they would get upset . . . so I forced myself to do it, but I didn't enjoy it at all. . . . Oh, I wish I wouldn't have asked them, but if I didn't ask them for 3 weeks, then somebody would [ask] what happened to those family dinners we used to have.

### Thematic Analysis: Activities Stopped During Depression

Analysis of activities stopped yielded four themes affecting participants' activity choices:

1. The activity is not meaningful to me now.
2. I no longer had the physical or cognitive energy to do it.
3. It's too physically painful.
4. I constricted my social space.

*The Activity Is Not Meaningful to Me Now.* When participants did not find activities sufficiently meaningful, they stopped participating. Activities were no longer meaningful when the process or outcome of the activity had no or less perceived value. For example, 1 participant considered mending to be a waste of time, whereas another identified going to the theater as not useful in resolving depression; hence, they stopped the activities. Moreover, activities ceased when participants did not care about themselves; 1 participant stopped clothes shopping when he was no longer concerned about his appearance. This theme was reflected by participants in terms such as *it didn't appeal to me, I thought it was a waste of time,* and *it never occurred to me to do it.* One gentleman explained,

> My interest in the computer was not what it used to be. . . . For 26 years, that's all I did at [work]. I was on bigger and larger machines [with] people counting on me . . . to take care of problems. Now, all of a sudden, I didn't care; in fact, I was ready to throw it out once.

*I No Longer Had the Physical or Cognitive Energy to Do It.* Some activities were stopped because of a decrease in physical or cognitive energy. Interestingly, some participants had the capacity to actively weigh activity options against their current energy level, prioritize activity choices, and allocate limited energy to the most meaningful activities, allowing them to remain engaged during the depressive state. In contrast, some participants' decisions to stop activities had a negative outcome. Decrease in physical energy, consistently described as "being tired," resulted in, for example, eliminating exercise and handicrafts. Decrease in cognitive energy was expressed by participants in terms such as *I couldn't concentrate on that, I can't get the clarity in my mind to do things like that,* and *trying to sit down and figure it out took so much energy.* One participant stopped paying bills, explaining,

> I have to get them all together. It's the organizing. I have to get my checks, checkbook, . . . the bills, . . . the envelopes, and the stamps, [and] I have to look at each one. The bills can pile up for weeks and weeks, and then I have to pay all those interest charges.

*It's Too Physically Painful.* Complaints of pain concomitant with depression triggered activity disengagement for some participants. Localized back pain or diffuse bodily pain in preparation for or during activity was sufficient for termination. This theme was expressed by participants in terms such as *my back was killing me, you're bent over like this and that's probably the worst position to be in,* and *by the time I arrive I feel as though I need a painkiller.* One man stopped going to spectator sports, stating, "I will not go and haven't been to the baseball or the football stadium because it's so difficult to get in and out."

*I Constricted My Social Space.* Some participants narrowed their world by limiting social interaction with others and, at times, even physical proximity to others. They restricted social interaction, for example, by not talking on the telephone or dining with friends because of the expectation to be social at least intermittently. This theme was described by participants in language such as *the last thing I want to be is social, I'd rather be by myself,* and *I didn't like people around me.* One gentleman explained that he was outgoing and social when not depressed but preferred to be alone when depressed. He did not entertain at home, stating, "Didn't like people around me. Period. I wanted to be alone."

## Discussion

We questioned older adults about their everyday activities during a depressive state. The available literature indicates that older adults limit their engagement in activities, beginning with IADLs (Lenze et al., 2001; Rogers & Holm, 1991), and alter both skills and habits during a depressive episode (Rogers & Holm, 2000). Our study sheds light on clients' insights as to why and how activity limitations occur during a depressive episode, providing guidance for occupational therapy assessments and interventions. Conceptually, our findings are consistent with the model of Selective Optimization With Compensation (SOC; Baltes & Baltes, 1990). In the SOC model, *selection* refers to prioritization followed by the

narrowing and focusing of one's high-efficacy areas of personal interest and alteration of one's expectations to permit satisfaction and self-control. *Optimization* refers to selecting and engaging in activities that increase the quality and quantity of reserve capacity. *Compensation* implies engaging in new behaviors or methods to reach desired goals when reserve capacity is insufficient.

Consistent with selection and optimization in the SOC model, our data indicate that some people continue IADLs when they are part of a habit or a commitment, remain gratifying, or are recognized as being in their best interest to continue. Consistent with compensation in the SOC model, our data suggest not only that people continue activities but also that some independently adapt activities so they can continue them, for example, by changing the process or the environment. We further broke down process adaptations into adaptations in range, methods, and time. Although some activities were continued, participants narrowed the range to activities that

- Had a prearranged commitment or accountability to another person,
- Were perceived as pleasurable,
- Were viewed as a means of self-preservation,
- Provided distraction,
- Supported efforts to hide depression from other people, and
- Were within their comfort level in social interaction.

Process adaptations also included method changes to facilitate participation, such as planning carefully ahead of time, narrowing options to expedite completion, and purchasing preassembled products to reduce preparation effort. Process adaptations related to time included engaging in activities at different times of the day than was typical and delaying the start of some activities.

We further broke down environment adaptations into adaptations involving people and physical space. Other people had a profound effect on supporting our study participants' participation in daily life tasks either directly, when others partnered with or prompted the participant, or indirectly, when participants chose to support a family member or remain active so as not to relinquish control to others or disclose their own depression. Adaptations involving physical space included changing the venue when participants' physical or cognitive energy or capacity for social interaction was diminished, physical pain was increased, or a neutral environment unrelated to past events was desired.

Four themes revealed influences that negatively affected functioning, which led participants to stop some activities. Consistent with the SOC model constructs of selection and optimization, participants stopped some activities (1) when the activity was no longer meaningful, (2) when the activity required more physical or cognitive energy than participants had or chose to expend, (3) when the activity was too physically painful to do, or (4) when the activity exceeded their self-constricted social space. Our data suggest that participants had two ways of thinking about stopping activities: positively and negatively. Negative thought processes were a response, for example, to disinterest or a perceived inability to adapt independently. Positive thought processes resulted in an adaptive approach, such as choosing to stop an activity to conserve limited energy for activities of higher priority.

Our findings show the importance of going beyond task difficulty, independence, or termination when evaluating clients with depression. Queries such as the following are more likely to provide insight into how the depressive episode is affecting daily life activities (Table 1):

- What activities have you continued to do to cope with the depressive episode—and why?
- Are you doing things differently than you did before? Can you tell me about the differences?
- What have you stopped doing that you used to do before you were depressed—and why?

Our results provide empirical evidence supporting the need for practitioners to complete a client-centered qualitative evaluation to understand activity engagement and disengagement.

Of particular interest to practitioners, each of the 10 themes clarifying why activities were continued or stopped has practical implications during client evaluations and interventions, whether preventive, restorative, or compensatory.

**Table 1. Assessment Questions for Practitioners**

| Question | Relevance |
|---|---|
| What activities have you continued to do to cope with the depressive episode? Why? | The practitioner will understand which activities the client needed, wanted, or was expected to do. |
| Are you doing things differently than you did before? Can you tell me about the differences? | The practitioner will learn of the client's capacity to adapt by using a compensatory strategy to continue valued activities. |
| What have you stopped doing that you used to do before you were depressed? Why? | The practitioner will ascertain whether the motive had a negative focus (e.g., lack of interest or pleasure), suggesting a maladaptive response, or had a positive focus (e.g., prioritization of energy or time), suggesting an adaptive response. |

For instance, during evaluation, practitioners can probe the client and significant others to learn of long-standing habits incorporating prearranged activities or commitments for use as a strategy to facilitate continued engagement during the depressive episode (*Established habits and commitments kept me engaged*). For example, a weekly bridge game with friends can be built into the schedule of expectations because it is already habitual. We recommend modifications for successful participation such as enlisting a family member to provide transportation or holding the bridge game at the client's own home to eliminate the need for transportation. Each of the 10 themes lends itself to a key strategy outlined in Table 2, whether done in the typical manner or with modifications.

## Limitations and Future Research

This study has strengths and limitations. The strengths involve a well-characterized sample that had been thoroughly evaluated for depression using well-accepted measures. Our sample was relatively homogeneous—primarily White women with a high educational level. We interviewed 27 people; in reviewing our data, we identified no new themes after the 18th person, but the data continued to be enriched and supported the themes previously identified. A limitation is that we interviewed participants about their depressive episode when they were in recovery, which may have altered their narratives because of recall bias. However, we used the ACS to structure the interview and facilitate recall.

On the basis of findings from this study and literature reviewed, further research is recommended to address the following questions:

- Why do some people continue and adapt activities independently?
- Were activities stopped because it was not possible to adapt them, or would clients have benefited from assistance from an occupational therapy practitioner?
- Can a mechanism be identified to anticipate the activity trajectory of older adults to prevent decline and maximize participation during a depressive episode?
- Does this qualitative assessment have utility across practice settings and age groups?

## Implications for Occupational Therapy Practice

Our findings have the following implications for addressing the complexity of activity engagement and disengagement of older adults during a depressive episode:

- Conduct a client-centered assessment to understand why activities are continued and stopped, using a semi-structured qualitative interview to ascertain the client's ability to adapt (see Table 1).
- Identify potential clients whose participation is compromised when they are unable to independently adapt

**Table 2. Key Strategies for Practitioners**

| Theme | Key Strategies for Practitioners |
|---|---|
| Established habits and commitments kept me engaged. | Probe for long-standing habits that incorporate prearranged activities or commitments because these may be a strategy to facilitate continued engagement during the depressive episode. |
| | Reinforce activity engagement by prearranging commitments and encouraging follow through with the client or family and friends. |
| Some activities were still gratifying. | Encourage continued involvement in activities that remain pleasurable or incite a sense of accomplishment. |
| Family and friends nudged me into action. | Coach family and friends to facilitate participation in activities and suggest ways to do so. For some people, grandchildren provide a specific source of activity prompting. |
| I gotta keep going. | Reinforce positive outcomes of activity engagement with the client and family and friends while pointing out negative consequences of inactivity. |
| Distraction and escape took me away from my situation. | Probe for and support activities that promote constructive use of time while providing an outlet to redirect thinking away from the client's less-than-optimal situation. |
| I'm hiding my depression from other people. | Educate family and friends about depressive symptoms, the need to remain vigilant to recognize early signs of depression, and benefits of early communication with health care providers to initiate intervention. |
| The activity is not meaningful to me now. | Identify activities that are meaningful to the client and encourage participation, recognizing that activities may vary at given time points. |
| | Recommend adapted strategies for completion of activities that, if forfeited, would likely be detrimental to the client. |
| I no longer had the physical or cognitive energy to do it. | Encourage the client to weigh activity options, and when insufficient reserve capacity prevents completion of all activities, select the most meaningful activity for engagement. |
| It's too physically painful. | Identify activities the client can realistically carry out in the usual way, or suggest modifications to the method used to allow successful engagement. |
| I constricted my social space. | Probe for meaningful activities that match the client's current capacity for social interaction. |

and who might benefit from occupational therapy intervention.
- Consider implementation of key strategies for practitioners identified in Table 2.

## Conclusion

The results of this study demonstrate how activities shaped the lives of older adults when they were depressed. Participants continued some activities, even initiating adaptations to enable engagement. Moreover, some participants deliberately stopped certain activities so as to direct limited energy to their highest priority activities. Practitioners are encouraged to use open-ended queries to understand what and, most important, why activities are continued or stopped, thereby guiding effective interventions. ▲

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