

Article

Evaluating the Efficacy of Psychiatric Interventions on Occupational Dysfunction in Major Depressive and Anxiety Disorder Patients

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Abstract: This study investigates the impact of psychiatric interventions on occupational dysfunction in patients with major depressive disorder (MDD) and anxiety disorder (AD). Occupational dysfunction is a significant concern in these populations, severely impairing the ability to perform daily activities and fulfill work and social roles. This research seeks to evaluate how different psychiatric interventions, including pharmacotherapy and psychotherapy, affect patients' occupational performance and overall quality of life. This study analyzed data from outpatients diagnosed with MDD and AD based on ICD-10 criteria. Participants were assessed before and after intervention using scales that measure anxiety, depression, and occupational task difficulty. Results demonstrated a significant improvement in patients' ability to perform a wide range of tasks, including personal hygiene, work-related activities, and social engagement, following treatment. The study highlights the importance of a multidisciplinary approach, emphasizing that both pharmacotherapy and psychotherapy significantly contribute to reducing occupational dysfunction and enhancing quality of life. These findings underscore the need for tailored interventions that address the specific occupational challenges faced by individuals with MDD and AD, aiming for long-term functional recovery.

Keywords: major depressive disorder; anxiety disorder; psychiatric interventions; occupational dysfunction; pharmacotherapy; psychotherapy



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1. Introduction

Various stressors impact individuals, including changes in social and productive roles, declining health, and the loss of close relationships. Although adulthood can be a period of growth and positive societal contributions, many people face mental health challenges such as major depressive disorder (MDD) and anxiety disorder (AD) [1]. MDD and AD are among the most debilitating common health conditions worldwide and significantly impact the quality of life for both patients and their families [2,3]. These conditions lead to occupational dysfunction [4–6], increased use of healthcare services, substantial economic expense, and a considerable burden on public health [7,8]. As life expectancy increases globally, including in Greece, where this study was based, more people are accessing mental health services [9]. It is therefore an opportune time to explore how therapists working on mental health teams can enable adults with MDD and/or AD to achieve well-being in their occupational lives.

MDD is a persistent mental health condition that affects 5–20% of individuals over the course of their lifetime [2,10]. It is characterized by a perpetual low mood, diminished motivation, fatigue, anhedonia, sleep disruptions, difficulty concentrating, and pervasive

feelings of despair [11]. These symptoms lead to functional impairments both at home and in the workplace, causing a significant and long-term decline in quality of life [12–14]. Moreover, MDD has been identified as the fourth largest contributor to the global disease burden and is projected to become the second leading cause of disability-adjusted life-years (DALYs) by 2020 and the leading cause by 2030, according to the Global Burden of Disease Study [15–17].

AD is marked by ongoing and pervasive worry. This worry, which spans multiple areas such as health, finances, family and the future, is typically excessive and hard to manage, and is often accompanied by various psychological and physical symptoms [18,19]. AD is especially common in primary care environments, affecting about 7 to 8% of patients [20]. However, patients seldom mention worry as a symptom. Instead, in primary care settings, AD usually presents with physical symptoms such as headaches or gastrointestinal issues [21]. The term “anxiety disorder” might misleadingly imply that the symptoms are entirely nonspecific, which can lead to its inappropriate use for almost any anxious patient. The term “worry disorder” was considered for the fifth edition of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-5) but was not adopted [11]. Nonetheless, excessive worry remains the central and defining characteristic of AD.

Occupational dysfunction is acknowledged globally as a significant health issue within the realm of preventive occupational therapy [22]. Occupation is seen as central to the human experience, encompassing activities that people need to do, want to do, and are expected to do [23]. Specifically, occupation spans numerous categories such as leisure, housework, sleep, and personal care. It encompasses not only work, business, and labor but also a broad array of activities including education, play, daily living tasks, rest, and social engagement [24]. Occupational imbalance refers to a disruption in the equilibrium of participating in daily activities [25]. Occupational alienation occurs when an individual’s intrinsic needs related to daily activities remain unfulfilled [26]. Moreover, occupational deprivation describes the absence of opportunities for daily activities due to factors beyond the individual’s control [27]. These issues hinder social participation and diminish health-related quality of life [28].

Occupational dysfunction is a significant issue for patients with both MDD and AD, as these conditions severely impair their ability to engage in daily activities and maintain work, social, and personal responsibilities [19,29]. Evaluating the efficacy of psychiatric interventions on occupational dysfunction in these patients is crucial, as effective treatments can help restore balance in daily activities, improve overall quality of life, and enhance social participation [30]. This evaluation is essential for developing targeted therapies that address both the psychological symptoms and the functional impairments caused by these disorders, ultimately leading to better patient outcomes and reducing the public health burden. However, addressing the global burden of these disorders is complicated by a matrix of factors, including the lack of reliable and valid biomarkers, unknown etiopathogenesis, continuous scarcity of mental health care investment, the unclear role of comorbidity, and health system weaknesses in delivering quality, personalized care [31]. Furthermore, the overreliance on imperfect binary diagnostic classification does not effectively capture the heterogeneous subtypes, progression, and outcomes of these mental disorders [32].

Evaluating the efficacy of psychiatric interventions is crucial for understanding and improving occupational functioning in patients with MDD and AD [33,34]. Increased access to evidence-based medical and psychological treatments, investment in major public health initiatives, development of digital health technologies, and novel models for understanding MDD and AD have the potential to inspire genuine improvements in managing these conditions and reducing their impact on daily functioning and quality of life. This study aims to evaluate the impact of psychiatric interventions on the occupational profiles of patients with MDD and AD, while also examining the effects of different psychiatric interventions (pharmacotherapy, psychotherapy, or a combination of both) on various aspects of occupational functioning. Additionally, the study compares the efficacy of these therapeutic interventions in enhancing patient outcomes.

The primary objective of this study is to determine the effectiveness of psychiatric interventions, from the perspective of occupational science, in addressing occupational dysfunction. Furthermore, the study aimed to highlight the importance of a multidisciplinary approach in the treatment of MDD and AD.

2. Materials and Methods

The study sample comprised 102 patients, including 45 males and 57 females. Of these, 68 patients were diagnosed with AD and 34 with MDD. Diagnoses were made by two independent psychiatrists based on the ICD-10 classification of mental and behavioral disorders [35]. Diagnoses were made independently by the two psychiatrists for each patient. Throughout the study, each patient was monitored and treated by the same psychiatrist. The type of psychotherapy provided was supportive psychotherapy. Patients attended sessions with their therapist once a week, and each patient received a total of 16 sessions, with each session lasting 50 min at a pre-scheduled day and time. Regarding pharmacotherapy, patients were administered SSRIs (escitalopram, sertraline, fluoxetine, citalopram, and paroxetine), SNRIs (venlafaxine), as well as mirtazapine, vortioxetine, and trazodone. In addition, some patients received benzodiazepines (alprazolam and bromazepam), which were administered at the beginning of the treatment but later discontinued. The data collection instrument was a questionnaire consisting of thirty-three (33) questions. The questionnaire was developed based on the *Occupational Therapy Practice Framework: Domain and Process*, 4th edition (OTPF-4) [23]. The first eleven (11) questions pertained to the personal/demographic characteristics of the participants, specifically: age, gender, religion, nationality, immigration/refugee status, education, employment status, marital status, number of children, and sexual orientation.

The subsequent questions were designed based on the research questions under consideration. Questions twelve and thirteen (12, 13) concerned the importance and difficulty of certain tasks and were of the Likert type (0 = not difficult at all to 5 = very difficult). Question fourteen (14) pertained to the importance of certain habits and was also of the Likert type (0 = not important at all to 5 = very important). Questions fifteen to seventeen (15–17) clarified the roles participants might have in their daily lives. Question 15 was a closed-ended question with free choice, while questions 16 and 17 were role-ranking questions. Questions 18–33 related to activities, communication, environment, and possible exclusion of the sample units. Questions 18, 19, 21, 22, 23, 24, 25, 26, 28, 30, and 32 were binary (Yes/No). Question 27 was a closed-ended question with free choice. Questions 20, 29, 31, and 33 were closed-ended questions (never, rarely, often).

In the context of this study, “importance” refers to the subjective value or priority that individuals assign to specific tasks in their daily lives. It reflects how essential they perceive a task to be in terms of its contribution to their overall well-being and functioning. On the other hand, “difficulty” refers to the perceived level of challenge or effort required to complete a given task. It measures how hard individuals find it to perform specific tasks due to their mental health condition, with higher difficulty indicating greater impairment in their ability to carry out the task.

A pilot study was conducted using this questionnaire with a population of 30 individuals, both with and without MDD and AD. The questionnaire was distributed to the patients before the start of treatment and after four months. To evaluate the reliability of the questionnaire variables, the researchers calculated Cronbach’s Alpha, which is appropriate for Likert-type scales. The scales were considered reliable (internally consistent) as the Alpha values were greater than 0.7 in both cases. To assess the validity of the questionnaire, Pearson correlations were calculated between variables within the same scale, and these correlations were found to be significant in all cases ($p < 0.05$).

Before the initiation of treatment and after four months, patients completed the Zung Self-Rating Depression Scale [36], STAI-Y1, and STAI-Y2 [37] to measure the severity of depression and anxiety symptoms.

Patients were divided into different intervention groups: pharmacotherapy, psychotherapy, or a combination of both. All patients were monitored throughout their treatment by the same psychiatrist.

Data were analyzed using IBM SPSS Statistics 26.0 [38]. The statistical analyses included: descriptive statistics, frequency tables, percentages, and mean values were constructed to present the data. Inferential statistical methods were employed to analyze the data. *t*-Testing was used to compare the mean values of Likert-type variables as well as the scales STAI-Y1, STAI-Y2, and Zung. A paired samples *t*-test was applied to compare mean values of variables from the same individuals measured at two different points in time. When assessing the impact of factors with more than two categories on the Likert-type variables and the STAI-Y1, STAI-Y2, and Zung scales, one-way ANOVA was utilized. In cases where the assumptions for one-way ANOVA were not satisfied, the Kruskal–Wallis H test, a non-parametric alternative, was conducted. Additionally, Pearson’s correlation coefficient (*r*) was used to evaluate the correlation between quantitative data. The significance level for all statistical tests was set at 0.05.

3. Results

3.1. Demographic Characteristics of the Sample

The study included 102 patients, consisting of 45 men and 57 women. Among these patients, 68 were diagnosed with AD and 34 with MDD (Table 1). Table 1 provides demographic information about the participants. It shows that the sample consisted of slightly more women than men. Most participants had completed high school or higher education. The age distribution of the sample was wide, with the majority falling between 25 and 54 years old. In addition, a significant portion of the participants had one or two children. Regarding employment status, the sample included a mix of employed, self-employed, and unemployed individuals. Moreover, most participants were married, reflecting the demographic characteristics of the group.

Table 1. Personal Characteristics (Frequencies and Percentages %).

Gender	Men: 45 (44.1)			Women: 57 (55.9)		
Educational Level	Elementary 2 (1.9)	Secondary School/High school 37 (36.3)		Vocational/Technical/University 41 (40.2)	Postgraduate/Doctorate 22 (21.6)	
Age	18–24 6 (5.9)	25–34 25 (24.5)	35–44 33 (32.4)	45–54 19 (18.6)	55–64 15 (14.7)	64+ 4 (3.9)
Children	0 30 (29.4)	1 37 (36.3)		2 26 (25.5)	3+ 9 (8.8)	
Employment Status	Unemployed/Trainee 22 (21.6)	Public/Private Employee 40 (39.2)		Self-employed 24 (23.5)	Homemaker/Retired/ Other 16 (15.7)	
Marital Status	Single 37 (36.3)	Married 53 (52)		Divorced 11 (10.8)	Widowed1 (0.9)	

3.2. Diagnosis and Treatment

According to the diagnosis and treatment, the majority of participants were diagnosed with AD, and a smaller group with MDD. Regarding treatment, the approaches were varied, with some participants receiving medication, some undergoing psychotherapy, and others receiving a combination of both. Table 2 details the types of mental health conditions diagnosed and the therapeutic approaches used.

Table 2. Diagnosis and Treatment (Frequencies and Percentages %).

Diagnosis	Anxiety Disorder: 68 (66.7)		Major Depressive Disorder: 34 (33.3)
Therapeutic Approach	Medication: 22 (21.6)	Psychotherapy: 35 (34.3)	Medication + Psychotherapy: 45 (44.1)

3.3. Psychiatric Intervention and Symptom Improvement

The results from the paired samples *t*-tests indicated significant improvements in anxiety and depression symptoms following psychiatric intervention (Table 3). Both STAIY1 and STAIY2 scores, which measure different aspects of anxiety, showed significant reductions after treatment. Similarly, the Zung scale, which measures depression severity, also showed a significant reduction.

Table 3. STAIY1, STAIY2, and Zung Scales before and after Psychiatric Intervention (paired samples *t*-test).

STAIY1	Before intervention: M = 58.427, SD = 10.653 After intervention: M = 35.427, SD = 8.409 $t(67) = 17.921, p < 0.001$
STAIY2	Before intervention: M = 57.618, SD = 9.313 After intervention: M = 36.471, SD = 7.074 $t(67) = 19.135, p < 0.001$
Zung	Before intervention: M = 57.235, SD = 9.065 After intervention: M = 39.324, SD = 9.419 $t(33) = 11.614, p < 0.001$

3.4. Task Importance, Difficulty, and Psychiatric Intervention

The change in the importance of tasks, with the exception of bathing/showering and meal preparation/cleanup, was statistically significant. It appears that after psychiatric intervention, patients considered tasks, except for bathing/showering and meal preparation/cleanup, to be more important compared with before the intervention (Table 4).

Table 4. Importance of Activities for Patients before and after Psychiatric Intervention (paired samples *t*-test).

Personal Hygiene/Grooming	$t(101) = -7.936, p < 0.001$
Dressing	$t(100) = -4.804, p < 0.001$
Physical Activity	$t(101) = -9.197, p < 0.001$
Sexual Activity	$t(100) = -7.362, p < 0.001$
Care for Others	$t(101) = -3.902, p < 0.001$
Driving/Using Public Transport	$t(101) = -5.710, p < 0.001$
Health Management	$t(101) = -7.138, p < 0.001$
Emergency Handling	$t(101) = -4.452, p < 0.001$
Shopping	$t(101) = -7.032, p < 0.001$
Rest	$t(101) = -6.722, p < 0.001$
Sleep Preparation	$t(101) = -4.505, p < 0.001$
Participation in Sleep	$t(101) = -5.02, p < 0.001$
Job Search	$t(99) = -7.708, p < 0.001$
Paid or Unpaid Work	$t(96) = -3.522, p = 0.001$
Participation in Volunteer Activities	$t(101) = -5.316, p < 0.001$
Participation in Leisure Activities	$t(101) = -6.334, p < 0.001$
Participation in Community Activities	$t(101) = -6.734, p < 0.001$
Participation in Family Activities	$t(101) = -5.062, p < 0.001$
Participation in Activities with Friends	$t(101) = -6.874, p < 0.001$

In addition, participants reported significantly less difficulty in a range of activities after psychiatric intervention, including personal hygiene, bathing/showering, dressing, physical activity, sexual activity, care for others, driving/using public transport, managing health, handling emergencies, preparing meals/clean up, shopping, resting, preparing for sleep, searching for jobs, working, participating in volunteer activities, engaging in leisure activities, involving themselves in the community, participating in family activities, and socializing with friends (Table 5).

Table 5. Difficulty in Activities before and after Psychiatric Intervention (paired samples *t*-test).

Personal Hygiene/Grooming	$t(101) = 3.279, p = 0.001$
Bathing/Showering	$t(101) = 3.799, p < 0.001$
Dressing	$t(100) = 4.204, p < 0.001$
Physical Activity	$t(101) = 7.042, p < 0.001$
Sexual Activity	$t(99) = 6.502, p < 0.001$
Care for Others	$t(101) = 5.676, p < 0.001$
Driving/Using Public Transport	$t(101) = 6.856, p < 0.001$
Health Management	$t(101) = 8.306, p < 0.001$
Emergency Handling	$t(101) = 5.780, p < 0.001$
Meal Preparation and Cleanup	$t(101) = 6.487, p < 0.001$
Shopping	$t(101) = 5.294, p < 0.001$
Rest	$t(101) = 4.983, p < 0.001$
Sleep Preparation	$t(101) = 5.406, p < 0.001$
Participation in Sleep	$t(101) = 4.418, p < 0.001$
Job Search	$t(99) = 4.676, p < 0.001$
Paid or Unpaid Work	$t(96) = 4.153, p < 0.001$
Participation in Volunteer Activities	$t(101) = 6.018, p < 0.001$
Participation in Leisure Activities	$t(100) = 7.384, p < 0.001$
Participation in Community Activities	$t(99) = 4.227, p < 0.001$
Participation in Family Activities	$t(100) = 4.090, p < 0.001$
Participation in Activities with Friends	$t(100) = 4.817, p < 0.001$

The paired samples *t*-test results for the frequency and perceived importance of smoking and alcohol use before and after the psychiatric intervention are presented in Table 6. The frequency of smoking showed a trend toward change following the psychiatric intervention, but this change was not statistically significant at the 0.05 level. Additionally, there was no significant change in the perceived importance of smoking. The frequency of alcohol use approached significance but did not reach the conventional threshold for statistical significance ($p < 0.05$), suggesting a possible but not definitive reduction in frequency of alcohol use post-intervention.

Table 6. Smoking, Alcohol Use and Importance before and after Psychiatric Intervention (Paired Samples *t*-Test).

Smoking Frequency	$t(100) = 1.809, p = 0.073$
Smoking Importance	$t(98) = 1.489, p = 0.140$
Alcohol Use Frequency	$t(99) = 1.923, p = 0.057$
Alcohol Use Importance	$t(98) = 4.463, p < 0.001$

In contrast, there was a highly significant decrease in the perceived importance of alcohol use following the psychiatric intervention, indicating that participants considered alcohol use less important after receiving treatment. This suggests that the treatment may have influenced participants' attitudes towards alcohol consumption, despite the lack of significant changes in the actual frequency of smoking or alcohol use.

3.5. Communication Patterns after Intervention

Table 7 presents the paired samples *t*-test results for communication behaviors before and after the psychiatric intervention. After the psychiatric intervention, there was a highly significant increase in the frequency of patients communicating to others that they were experiencing a mental illness. Following the psychiatric intervention, there was a highly significant increase in the frequency of patients communicating to others that they visit a psychiatrist. Similarly, post-intervention, there was a highly significant increase in the frequency of patients communicating to others that they were taking medication. After the psychiatric intervention, there was a highly significant increase in the frequency of patients communicating to others that they were undergoing psychotherapy.

Table 7. Communication before and after Psychiatric Intervention (Paired Samples *t*-Test).

Communicating Mental Illness to Others	$t(99) = 6.205, p < 0.001$
Communicating Visits to a Psychiatrist	$t(98) = 5.754, p < 0.001$
Communicating Use of Medication	$t(65) = 4.749, p < 0.001$
Communicating Participation in Psychotherapy	$t(89) = 5.205, p < 0.001$

3.6. Comparison of Therapeutic Approaches

The impact of different therapeutic approaches on changes in the STAIY1, STAIY2, and Zung scales before and after psychiatric intervention was examined (Table 8). The results of the ANOVA indicated no statistically significant difference in the mean scores between the groups defined by the therapeutic approach, for the STAIY1 scale ($F(2, 98) = 1.396, p = 0.253$), the STAIY2 scale ($F(2, 99) = 0.500, p = 0.608$), nor the Zung scale ($F(2, 99) = 1.936, p = 0.150$).

Table 8. Comparison of Psychotherapy and Medication (ANOVA).

STAIY1	$F(2, 98) = [1.396], p = 0.253$
STAIY2	$F(2, 99) = [0.500], p = 0.608$
Zung	$F(2, 99) = [1.936], p = 0.150$

This suggests that the type of psychiatric intervention—whether psychotherapy, medication, or a combination—did not result in significantly different outcomes in terms of reducing symptoms of anxiety and depression as measured by the STAIY1, STAIY2, and Zung scales.

The Kruskal–Wallis H test showed that individuals undergoing only psychotherapy perceived certain tasks as less difficult, compared with those receiving other forms of psychiatric interventions. Specifically, Table 9 presents the Kruskal–Wallis test results comparing the effects of different types of psychiatric interventions (pharmacotherapy, psychotherapy, or a combination of both) on the perceived importance and difficulty of various activities.

A statistically significant difference in the perceived difficulty of activities among the different therapy groups is indicated by a *p*-value of less than 0.05. For instance, those undergoing only psychotherapy (mean rank = 36.47) perceive “Job Seeking” as less difficult, compared with the others (mean rank = 58.47, mean rank = 52.84), with the test results showing $\chi^2 = 11.170, p = 0.004, df = 2$, following psychiatric intervention. Furthermore,

individuals undergoing only psychotherapy (Mean Rank = 40.33) perceived “Participation in Voluntary Activities” as less difficult compared with the others (mean rank = 52.18, mean rank = 57.13), with the test results showing $\chi^2 = 7.249$, $p = 0.027$, $df = 2$, following psychiatric intervention.

Table 9. Type of Psychiatric Intervention and Importance/Difficulty of Activities (Kruskal–Wallis Test).

Activities	Importance	Difficulty
Job Search	$\chi^2 = 0.052$, $p = 0.974$, $df = 2$	$\chi^2 = 11.170$, $p = 0.004$, $df = 2$
Participation in Volunteer Activities	$\chi^2 = 2.381$, $p = 0.304$, $df = 2$	$\chi^2 = 7.249$, $p = 0.027$, $df = 2$

These findings suggest that psychotherapy alone may be particularly effective in reducing the perceived difficulty of engaging in job-seeking and voluntary activities post-intervention, highlighting the potential benefits of targeted psychotherapeutic approaches in these areas.

Moreover, statistically, educational level does not appear to have significantly affected the difficulty of tasks before and after the psychiatric therapeutic intervention.

Table 10 shows the Kruskal–Wallis H test results for parenting and significance/difficulty of tasks before and after the psychiatric therapeutic intervention. The Kruskal–Wallis H test indicated that the absence of children significantly reduced the difficulty of completing certain tasks. The absence of children (mean rank = 39.78) significantly reduced difficulty in personal hygiene/grooming compared with the presence of children (mean rank = 48.78, mean rank = 55.41). Similarly, the results show that the absence of children reduce difficulty in care for others, shopping, paid or unpaid work and participation in family activities.

Table 10. Parenting and Importance/Difficulty of Tasks before and after Psychiatric Therapeutic Intervention.

Activities	Importance	Difficulty
Personal Hygiene/Grooming	$\chi^2 = 2.596$, $p = 0.273$, $df = 2$	$\chi^2 = 6.002$, $p = 0.05$, $df = 2$
Care for Others	$\chi^2 = 2.481$, $p = 0.289$, $df = 2$	$\chi^2 = 6.995$, $p = 0.030$, $df = 2$
Shopping	$\chi^2 = 1.450$, $p = 0.484$, $df = 2$	$\chi^2 = 6.077$, $p = 0.048$, $df = 2$
Paid or Unpaid Work	$\chi^2 = 1.065$, $p = 0.587$, $df = 2$	$\chi^2 = 7.789$, $p = 0.020$, $df = 2$
Participation in Family Activities	$\chi^2 = 1.140$, $p = 0.566$, $df = 2$	$\chi^2 = 8.025$, $p = 0.018$, $df = 2$

The analysis of Pearson’s correlation coefficients revealed notable insights into the relationship between age, task difficulty, and task importance. Age exhibited a significant weak positive correlation with changes in the difficulty of tasks such as “Personal Hygiene/Grooming” ($r(102) = 0.197$, $p = 0.047$), “Care for Others” ($r(102) = 0.218$, $p = 0.028$) and “Participation in Family Activities” ($r(101) = 0.203$, $p = 0.042$). This suggests that older individuals tended to perceive these tasks as increasingly challenging. Additionally, age showed a significant weak negative correlation with changes in the importance of tasks like “Personal Hygiene/Grooming” ($r(102) = -0.222$, $p = 0.025$), and “Participation in Voluntary Activities” ($r(102) = -0.243$, $p = 0.014$). These findings indicate that with advancing age, individuals may perceive these activities as less important, potentially reflecting a shift in priorities or changes in perception related to aging (Table 11).

Further analysis using the Kruskal–Wallis H test revealed additional significant findings in Table 12. The change in the importance of the task “Physical Activity” after psychiatric intervention was notably smaller for those engaged in household activities (mean rank = 22.17) compared with the other groups, with a significant difference ($\chi^2 = 14.307$, $p = 0.026$, $df = 6$). Similarly, the change in the importance of “Participation in Activities with Friends” after intervention was significantly smaller for individuals involved in household tasks (Mean Rank = 18.28) relative to others ($\chi^2 = 15.143$, $p = 0.017$, $df = 6$).

Table 11. Age and Importance/Difficulty of Tasks before and after Psychiatric Therapeutic Intervention (Pearson's r).

Activities	Importance	Difficulty
Personal Hygiene/Grooming	$r(102) = -0.222, p = 0.025$	$r(102) = 0.197, p = 0.047$
Care for Others	$r(102) = -0.004, p = 0.966$	$r(102) = 0.218, p = 0.028$
Participation in Volunteer Activities	$r(102) = -0.243, p = 0.014$	$r(100) = 0.146, p = 0.148$
Participation in Family Activities	$r(102) = -0.051, p = 0.609$	$r(101) = 0.203, p = 0.042$

Table 12. Employment Status and Importance/Difficulty of Tasks before and after psychiatric therapeutic intervention.

Activities	Importance	Difficulty
Physical Activity	$\chi^2 = 14.307, p = 0.026, df = 6$	$\chi^2 = 5.103, p = 0.531, df = 6$
Job Search	$\chi^2 = 1.378, p = 0.967, df = 6$	$\chi^2 = 12.926, p = 0.044, df = 6$
Participation in Activities with Friends	$\chi^2 = 15.143, p = 0.017, df = 6$	$\chi^2 = 5.238, p = 0.514, df = 6$

Additionally, the change in the difficulty of "Job Seeking" after psychiatric intervention was significantly less for unemployed individuals (Mean Rank = 30.07) compared with the other groups, with a significant difference observed ($\chi^2 = 12.926, p = 0.044, df = 6$). These findings indicate that different types of interventions and patient activities may have varying impacts on the perceived difficulty and importance of different tasks. This underscores the need for personalized approaches in psychiatric care to effectively address individual needs and challenges.

Patients with AD placed significant importance on a variety of tasks, including personal hygiene (bathing/showering), dressing, physical activity, sexual activity, caregiving, driving/using public transportation, health management, sleeping, participating in community activities, and engaging in social activities with friends. This group also appears to have experienced less difficulty with tasks such as personal hygiene/grooming, bathing/showering, dressing, caregiving, driving/using public transportation, handling emergencies, meal preparation and space organization, paid or unpaid work, participation in volunteer activities, engaging in activities with friends, health management, sleeping, community activities, leisure activities, and social interactions with friends.

However, the most significant challenges faced by this group were in relation to job seeking, as highlighted in Table 13. This indicates that while patients with anxiety disorders manage many tasks relatively well, job seeking remains a particularly difficult area for them.

Patients with MDD prioritized tasks such as personal hygiene/grooming, bathing/showering, health management, handling emergencies, rest, sleep preparation, and participation in sleep. In contrast, tasks such as participation in volunteer activities and community involvement were considered less important by this group. Patients with MDD experienced less difficulty with bathing/showering and dressing, whereas they encountered more significant challenges with participating in volunteer activities and community activities, as outlined in Table 14.

Statistical analyses revealed significant differences in the perceived importance and difficulty of various tasks between patients with AD and those with MDD. Patients with AD rated "Job Seeking" as more important compared with their counterparts with MDD following psychiatric intervention. Additionally, these patients perceived "Dressing" as less difficult both before and after the therapeutic intervention. Conversely, "Health Management" was considered less difficult only after the psychiatric treatment. These differences are detailed in Tables 15 and 16, underscoring the varying impacts of psychiatric interventions on task perception across different patient groups.

Table 13. Diagnosed with Anxiety Disorder(*t*-Test, Critical Value = 2.5).

Activities	Importance	Difficulty
Personal Hygiene/Grooming	$t(67) = 0.340, p = 0.735$	$t(67) = -7.678, p < 0.001$
Bathing/Showering	$t(67) = 5.025, p < 0.001$	$t(67) = -4.420, p < 0.001$
Dressing	$t(67) = 4.850, p < 0.001$	$t(67) = -8.135, p < 0.001$
Physical Activity	$t(67) = 3.302, p = 0.002$	$t(67) = -1.817, p = 0.074$
Sexual Activity	$t(67) = 7.899, p < 0.001$	$t(67) = -0.355, p = 0.723$
Care for Others	$t(67) = 18.180, p < 0.001$	$t(67) = -3.899, p < 0.001$
Driving/Using Public Transport	$t(67) = 6.279, p < 0.001$	$t(67) = -2.334, p = 0.023$
Health Management	$t(67) = 15.553, p < 0.001$	$t(67) = 1.092, p = 0.279$
Emergency Handling	$t(67) = 1.911, p = 0.060$	$t(67) = -2.611, p = 0.011$
Meal Preparation and Cleanup	$t(67) = 1.121, p = 0.266$	$t(67) = -4.361, p < 0.001$
Participation in Sleep	$t(67) = 2.348, p = 0.022$	$t(67) = -0.441, p = 0.661$
Job Search	$t(67) = -0.482, p = 0.631$	$t(63) = 2.325, p < 0.023$
Paid or Unpaid Work	$t(66) = -0.032, p = 0.974$	$t(62) = -5.093, p < 0.001$
Participation in Volunteer Activities	$t(67) = 1.214, p = 0.229$	$t(66) = -3.146, p = 0.002$
Participation in Leisure Activities	$t(67) = 0.983, p = 0.329$	$t(66) = -3.750, p < 0.001$
Participation in Family Activities	$t(67) = 8.058, p < 0.001$	$t(66) = -1.459, p = 0.149$
Participation in Activities with Friends	$t(67) = 13.530, p < 0.001$	$t(66) = -6.070, p < 0.001$

Table 14. Diagnosed with Major Depressive Disorder(*t*-Test, Critical Value = 2.5).

Activities	Importance	Difficulty
Personal Hygiene/Grooming	$t(33) = 5.404, p < 0.001$	$t(33) = -1.401, p = 0.170$
Bathing/Showering	$t(33) = 6.976, p < 0.001$	$t(33) = -2.279, p = 0.029$
Dressing	$t(33) = 1.896, p = 0.067$	$t(33) = -2.306, p = 0.028$
Health Management	$t(33) = 2.178, p = 0.037$	$t(33) = 1.299, p = 0.203$
Emergency Handling	$t(33) = 3.138, p = 0.004$	$t(33) = 1.305, p = 0.201$
Rest	$t(33) = 3.708, p = 0.001$	$t(33) = -1.827, p = 0.077$
Sleep Preparation	$t(33) = 2.839, p = 0.008$	$t(33) = -0.889, p = 0.380$
Participation in Sleep	$t(33) = 6.019, p < 0.001$	$t(33) = -0.275, p = 0.785$
Participation in Volunteer Activities	$t(33) = -3.156, p = 0.003$	$t(33) = 3.835, p = 0.001$
Participation in Community Activities	$t(33) = -4.490, p < 0.001$	$t(33) = 2.704, p = 0.011$

Table 15. Importance of Tasks before and after the psychiatric intervention, according to Diagnosis (*t*-Test).

Job Search	$t(98) = 0.670, p = 0.504$	$t(98) = 2.318, p = 0.023$
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Table 16. Difficulty of Tasks before and after the psychiatric intervention, according to Diagnosis (*t*-Test).

Dressing	$t(99) = -2.391, p = 0.019$	$t(100) = -2.237, p = 0.027$
Health Management	$t(100) = -0.580, p = 0.563$	$t(100) = -2.180, p = 0.046$

Table 16 presents the results of *t*-Tests examining the difficulty of various tasks before and after psychiatric intervention, according to diagnosis.

The Pearson's correlation coefficient analysis revealed distinct patterns in the relationship between anxiety levels, as measured by the STAIY1 scale, and the perceived difficulty of various tasks both before and after psychiatric intervention, as outlined in Table 17.

Table 17. STAIY1 scores and Difficulty of Tasks before and after the psychiatric intervention (Diagnosed with Anxiety Disorder, Pearson's r).

Activities	Before	After
Personal Hygiene/Grooming	$r(68) = 0.019, p = 0.881$	$r(68) = 0.308, p = 0.011$
Bathing/Showering	$r(68) = 0.080, p = 0.516$	$r(68) = 0.400, p = 0.001$
Dressing	$r(68) = 0.025, p = 0.842$	$r(68) = 0.392, p = 0.001$
Sexual Activity	$r(68) = 0.383, p = 0.001$	$r(68) = 0.282, p = 0.021$
Health Management	$r(68) = 0.237, p = 0.052$	$r(68) = 0.297, p = 0.014$
Shopping	$r(68) = 0.363, p = 0.002$	$r(68) = 0.426, p < 0.001$
Rest	$r(68) = 0.241, p = 0.047$	$r(68) = 0.282, p = 0.020$
Sleep Preparation	$r(68) = 0.271, p = 0.026$	$r(68) = 0.467, p < 0.001$
Participation in Sleep	$r(68) = 0.417, p < 0.001$	$r(68) = 0.507, p < 0.001$
Job Search	$r(64) = 0.436, p < 0.001$	$r(62) = 0.524, p < 0.001$
Paid or Unpaid Work	$r(63) = 0.459, p < 0.001$	$r(62) = 0.242, p = 0.058$
Participation in Volunteer Activities	$r(67) = 0.304, p = 0.012$	$r(66) = 0.006, p = 0.962$
Participation in Leisure Activities	$r(67) = 0.275, p = 0.024$	$r(67) = 0.006, p = 0.962$
Participation in Community Activities	$r(67) = 0.348, p = 0.004$	$r(66) = 0.409, p < 0.001$
Participation in Family Activities	$r(67) = 0.327, p = 0.007$	$r(67) = 0.398, p = 0.001$
Participation in Activities with Friends	$r(67) = 0.245, p = 0.046$	$r(67) = 0.186, p = 0.132$

Before psychiatric intervention, the STAIY1 scale showed a significant moderate positive correlation with the difficulty of several tasks. Specifically, anxiety levels were positively correlated with the difficulty of "Sexual Activity" ($r(68) = 0.383, p = 0.001$), "Shopping" ($r(68) = 0.363, p = 0.002$), "Participation in Sleep" ($r(68) = 0.417, p < 0.001$), "Job Seeking" ($r(64) = 0.436, p < 0.001$), "Paid or Unpaid Work" ($r(63) = 0.459, p < 0.001$), "Participation in Volunteer Activities" ($r(67) = 0.304, p = 0.012$), "Participation in Community Activities" ($r(67) = 0.348, p = 0.004$), and "Participation in Family Activities" ($r(67) = 0.327, p = 0.007$). These results indicate that higher anxiety levels were associated with greater perceived difficulty in managing these tasks.

Additionally, the STAIY1 scale exhibited a significant weak positive correlation with the difficulty of tasks such as "Rest" ($r(68) = 0.241, p = 0.047$), "Sleep Preparation" ($r(68) = 0.271, p = 0.026$), "Participation in Leisure Activities" ($r(67) = 0.275, p = 0.024$), and "Participation in Activities with Friends" ($r(67) = 0.245, p = 0.046$). This suggests that while the association was weaker, higher anxiety still correlated with increased difficulty in these areas.

After psychiatric intervention, the STAIY1 scale reflected a strong positive correlation with the difficulty of "Participation in Sleep" ($r(68) = 0.507, p < 0.001$) and "Job Seeking" ($r(68) = 0.524, p < 0.001$). These findings indicate that, following intervention, anxiety levels were strongly associated with greater difficulty in these specific tasks.

Moreover, after intervention, the STAIY1 scale showed a significant moderate positive correlation with the difficulty of "Personal Hygiene/Grooming" ($r(68) = 0.308, p = 0.011$), "Bathing/Showering" ($r(68) = 0.400, p = 0.001$), "Dressing" ($r(68) = 0.392, p = 0.001$), "Shopping" ($r(68) = 0.426, p < 0.001$), "Sleep Preparation" ($r(68) = 0.467, p < 0.001$), "Participation in Community Activities" ($r(66) = 0.409, p < 0.001$), and "Participation in Family Activities" ($r(67) = 0.398, p = 0.001$). These results indicate that, post-intervention, anxiety levels were moderately associated with increased difficulty in managing these tasks.

Finally, there was a significant weak positive correlation between anxiety levels and the difficulty of "Sexual Activity" ($r(68) = 0.282, p = 0.021$), "Health Management" ($r(68) = 0.297, p = 0.014$), and "Rest" ($r(68) = 0.282, p = 0.020$) after the intervention. This suggests that

while the relationship was weaker compared with other tasks, higher anxiety still correlated with increased difficulty in these areas post-intervention.

The Pearson's correlation coefficient analysis provided insight into the relationship between anxiety levels, as measured by the STAIY2 scale, and the perceived difficulty of various tasks both before and after psychiatric intervention, as outlined in Table 18.

Table 18. STAIY2 scores and Difficulty of Tasks before and after the psychiatric intervention (Diagnosed with Anxiety Disorder, Pearson's r).

Activities	Before	After
Bathing/Showering	$r(68) = 0.202, p = 0.098$	$r(68) = 0.307, p = 0.011$
Dressing	$r(68) = 0.141, p = 0.251$	$r(68) = 0.371, p = 0.002$
Physical Activity	$r(68) = 0.158, p = 0.199$	$r(68) = 0.289, p = 0.017$
Sexual Activity	$r(68) = 0.273, p = 0.024$	$r(68) = 0.165, p = 0.183$
Driving/Using Public Transport	$r(68) = 0.332, p = 0.006$	$r(68) = 0.277, p = 0.022$
Health Management	$r(68) = 0.382, p = 0.001$	$r(68) = 0.317, p = 0.008$
Emergency Handling	$r(68) = 0.304, p = 0.012$	$r(68) = 0.016, p = 0.898$
Shopping	$r(68) = 0.441, p < 0.001$	$r(68) = 0.414, p < 0.001$
Rest	$r(68) = 0.264, p = 0.030$	$r(68) = 0.245, p = 0.044$
Sleep Preparation	$r(68) = 0.389, p = 0.001$	$r(68) = 0.411, p < 0.001$
Participation in Sleep	$r(68) = 0.429, p < 0.001$	$r(68) = 0.384, p = 0.001$
Job Search	$r(64) = 0.442, p < 0.001$	$r(62) = 0.385, p = 0.002$
Paid or Unpaid Work	$r(63) = 0.470, p < 0.001$	$r(62) = 0.275, p = 0.030$
Participation in Volunteer Activities	$r(67) = 0.336, p = 0.005$	$r(66) = 0.110, p = 0.380$
Participation in Leisure Activities	$r(67) = 0.339, p = 0.005$	$r(67) = 0.107, p = 0.388$
Participation in Community Activities	$r(67) = 0.379, p = 0.002$	$r(66) = 0.387, p = 0.001$
Participation in Family Activities	$r(67) = 0.349, p = 0.004$	$r(67) = 0.303, p = 0.013$
Participation in Activities with Friends	$r(67) = 0.305, p = 0.012$	$r(67) = 0.208, p = 0.092$

Before the psychiatric intervention, the STAIY2 scale exhibited a significant moderate positive correlation with the difficulty of several tasks. Specifically, higher anxiety levels were associated with greater difficulty in "Driving/Using Public Transportation" ($r(68) = 0.332, p = 0.006$), "Health Management" ($r(68) = 0.382, p = 0.001$), "Handling Emergencies" ($r(68) = 0.304, p = 0.012$), "Shopping" ($r(68) = 0.441, p < 0.001$), "Sleep Preparation" ($r(68) = 0.389, p < 0.001$), "Participation in Sleep" ($r(68) = 0.429, p < 0.001$), "Job Seeking" ($r(64) = 0.442, p < 0.001$), "Paid or Unpaid Work" ($r(63) = 0.470, p < 0.001$), "Participation in Volunteer Activities" ($r(67) = 0.336, p = 0.005$), "Participation in Leisure Activities" ($r(67) = 0.339, p = 0.005$), "Participation in Community Activities" ($r(67) = 0.379, p = 0.002$), "Participation in Family Activities" ($r(67) = 0.349, p = 0.004$), and "Participation in Activities with Friends" ($r(67) = 0.305, p = 0.012$). These correlations suggest that increased anxiety was associated with heightened difficulty in managing these tasks.

Additionally, the STAIY2 scale showed a significant weak positive correlation with the difficulty of "Sexual Activity" ($r(68) = 0.273, p = 0.024$) and "Rest" ($r(68) = 0.264, p = 0.030$), indicating that anxiety had a weaker, but still notable, association with these areas of difficulty.

After the psychiatric intervention, the STAIY2 scale continued to reflect a significant moderate positive correlation with the difficulty of tasks such as "Bathing/Showering" ($r(68) = 0.307, p = 0.011$), "Dressing" ($r(68) = 0.371, p = 0.002$), "Health Management" ($r(68) = 0.317, p = 0.008$), "Shopping" ($r(68) = 0.414, p < 0.001$), "Sleep Preparation" ($r(68) = 0.411, p < 0.001$), "Participation in Sleep" ($r(68) = 0.384, p = 0.001$), "Job Seeking" ($r(62) = 0.385, p = 0.002$), "Participation

in Community Activities" ($r(66) = 0.387, p = 0.001$), and "Participation in Family Activities" ($r(67) = 0.303, p = 0.013$). These findings suggest that, post-intervention, anxiety remained moderately associated with increased difficulty in these tasks.

Furthermore, the STAIY2 scale showed a significant weak positive correlation with the difficulty of "Physical Activity" ($r(68) = 0.289, p = 0.017$), "Driving/Using Public Transportation" ($r(68) = 0.277, p = 0.022$), "Rest" ($r(68) = 0.245, p = 0.044$), and "Paid or Unpaid Work" ($r(62) = 0.275, p = 0.030$) after the intervention. This indicates that while the correlation was weaker compared with other tasks, higher anxiety levels still correlated with increased difficulty in these areas following the psychiatric intervention.

The Pearson's correlation coefficient analysis presented in Table 19 outlines the relationships between depression levels, as measured by the Zung scale, and the perceived difficulty of various tasks before and after psychiatric intervention.

Table 19. Zung scale scores and Difficulty of Tasks before and after the psychiatric intervention (Diagnosed with Major Depressive Disorder, Pearson's r).

Activities	Before	After
Bathing/Showering	$r(34) = 0.361, p = 0.036$	$r(34) = 0.019, p = 0.913$
Dressing	$r(34) = 0.609, p < 0.001$	$r(34) = 0.159, p = 0.369$
Care for Others	$r(34) = 0.589, p < 0.001$	$r(34) = 0.142, p = 0.423$
Driving/Using Public Transport	$r(34) = 0.502, p = 0.002$	$r(34) = 0.135, p = 0.446$
Health Management	$r(34) = 0.351, p = 0.042$	$r(34) = 0.410, p = 0.016$
Meal Preparation and Cleanup	$r(34) = 0.477, p = 0.004$	$r(34) = 0.522, p = 0.002$
Shopping	$r(34) = 0.436, p = 0.010$	$r(34) = 0.663, p < 0.001$
Paid or Unpaid Work	$r(33) = 0.371, p = 0.033$	$r(33) = 0.206, p = 0.249$
Participation in Volunteer Activities	$r(34) = 0.376, p = 0.028$	$r(34) = 0.143, p = 0.420$
Participation in Leisure Activities	$r(34) = 0.554, p = 0.001$	$r(34) = 0.180, p = 0.308$
Participation in Community Activities	$r(34) = 0.438, p = 0.010$	$r(34) = 0.314, p = 0.070$
Participation in Family Activities	$r(34) = 0.574, p < 0.001$	$r(34) = 0.337, p = 0.051$
Participation in Activities with Friends	$r(34) = 0.507, p = 0.002$	$r(34) = 0.336, p = 0.052$

Before Psychiatric Intervention:

The Zung scale revealed a significant strong positive correlation with the difficulty of several tasks. Notably, higher depression levels were strongly associated with increased difficulty in "Dressing" ($r(34) = 0.609, p < 0.001$), "Care for Others" ($r(34) = 0.589, p < 0.001$), "Driving/Using Public Transportation" ($r(34) = 0.502, p = 0.002$), "Participation in Leisure Activities" ($r(34) = 0.554, p < 0.001$), "Participation in Family Activities" ($r(34) = 0.574, p < 0.001$), and "Participation in Activities with Friends" ($r(34) = 0.507, p = 0.002$). This indicates that individuals with higher depression levels found these tasks significantly more difficult.

Additionally, the Zung scale demonstrated a significant moderate positive correlation with the difficulty of "Bathing/Showering" ($r(34) = 0.361, p = 0.036$), "Health Management" ($r(34) = 0.351, p = 0.042$), "Meal Preparation and Space Maintenance" ($r(34) = 0.477, p = 0.004$), "Shopping" ($r(34) = 0.436, p = 0.010$), "Paid or Unpaid Work" ($r(33) = 0.371, p = 0.033$), "Participation in Volunteer Activities" ($r(34) = 0.376, p = 0.028$), and "Participation in Community Activities" ($r(34) = 0.438, p = 0.010$). These moderate correlations suggest that higher depression levels were also associated with increased difficulty in managing these tasks, although to a lesser extent compared with the tasks with strong correlations.

After Psychiatric Intervention:

Post-intervention, the Zung scale continued to reflect a significant strong positive correlation with the difficulty of "Shopping" ($r(34) = 0.663, p < 0.001$) and "Meal Preparation

and Space Maintenance" ($r(34) = 0.522, p = 0.002$). This indicates that despite intervention, individuals with higher depression levels still experienced significant difficulty in these tasks.

Moreover, the Zung scale also showed significant moderate positive correlation with the difficulty of "Health Management" ($r(34) = 0.410, p = 0.016$) after the intervention. This suggests that, while the strength of the correlation was moderate, depression continued to significantly impact the perceived difficulty of managing health-related tasks following psychiatric treatment.

According to the Pearson's correlation coefficient analysis presented in Table 20, the relationships between anxiety levels, as measured by the STAIY1 scale, and the perceived importance of various tasks were assessed both before and after psychiatric intervention.

Table 20. STAIY1 scores and Importance of Tasks before and after the Psychiatric Intervention (Diagnosed with Anxiety Disorder, Pearson's r).

Activities	Before	After
Personal Hygiene/Grooming	$r(68) = -0.111, p = 0.366$	$r(68) = -0.403, p = 0.001$
Bathing/Showering	$r(68) = -0.125, p = 0.311$	$r(68) = -0.455, p < 0.001$
Dressing	$r(68) = -0.052, p = 0.647$	$r(68) = -0.314, p = 0.009$
Sexual Activity	$r(68) = -0.349, p = 0.004$	$r(68) = -0.207, p = 0.091$
Emergency Handling	$r(68) = -0.092, p = 0.456$	$r(68) = -0.383, p = 0.001$
Meal Preparation and Cleanup	$r(68) = -0.123, p = 0.316$	$r(68) = -0.268, p = 0.027$
Shopping	$r(68) = -0.236, p = 0.053$	$r(68) = -0.291, p = 0.016$
Rest	$r(68) = -0.201, p = 0.100$	$r(68) = -0.251, p = 0.039$
Participation in Sleep	$r(68) = -0.209, p = 0.087$	$r(68) = -0.278, p = 0.022$
Job Search	$r(68) = -0.161, p = 0.191$	$r(66) = -0.265, p = 0.031$
Paid or Unpaid Work	$r(67) = -0.092, p = 0.459$	$r(64) = -0.294, p = 0.018$
Participation in Leisure Activities	$r(68) = -0.213, p = 0.080$	$r(68) = -0.292, p = 0.016$
Participation in Community Activities	$r(68) = -0.318, p = 0.008$	$r(68) = -0.206, p = 0.091$
Participation in Family Activities	$r(68) = -0.311, p = 0.010$	$r(68) = -0.300, p = 0.013$
Participation in Activities with Friends	$r(68) = -0.294, p = 0.015$	$r(68) = -0.245, p = 0.044$

Before Psychiatric Intervention:

The STAIY1 scale showed a significant moderate negative correlation with the importance of several tasks. Specifically, higher anxiety levels were associated with decreased perceived importance of "Sexual Activity" ($r(68) = -0.349, p = 0.004$), "Participation in Community Activities" ($r(68) = -0.318, p = 0.008$), and "Participation in Family Activities" ($r(68) = -0.311, p = 0.010$). This suggests that individuals with higher anxiety levels tended to place less importance on these tasks. Also, the STAIY1 scale had a significant weak negative correlation with the importance of "Participation in Activities with Friends" ($r(68) = -0.294, p = 0.015$). This indicates that while the correlation is weaker, higher anxiety was still associated with a reduced perception of the importance of engaging in activities with friends.

After Psychiatric Intervention:

Post-intervention, the STAIY1 scale demonstrated a significant moderate negative correlation with the importance of several tasks. Higher anxiety levels were associated with a lower perceived importance of "Personal Hygiene/Grooming" ($r(68) = -0.403, p = 0.001$), "Bathing/Showering" ($r(68) = -0.455, p < 0.001$), "Handling Emergencies" ($r(68) = -0.383, p = 0.001$), and "Participation in Family Activities" ($r(68) = -0.300, p = 0.013$). This indicates that even after psychiatric intervention, individuals with higher anxiety levels continued to view these tasks as less important.

The STAIY1 scale also showed a significant weak negative correlation with the importance of “Meal Preparation and Space Maintenance” ($r(68) = -0.268, p = 0.027$), “Shopping” ($r(68) = -0.291, p = 0.016$), “Rest” ($r(68) = -0.251, p = 0.039$), “Participation in Sleep” ($r(68) = -0.278, p = 0.022$), “Job Search” ($r(66) = -0.265, p = 0.031$), “Paid or Unpaid Work” ($r(68) = -0.294, p = 0.018$), “Participation in Leisure Activities” ($r(68) = -0.292, p = 0.016$), and “Participation in Activities with Friends” ($r(68) = -0.245, p = 0.044$). These findings suggest that while the strength of the correlation was weaker, anxiety continued to influence the perceived importance of these tasks following psychiatric intervention.

According to Table 21, the Pearson’s correlation coefficient analysis provides insights into the relationship between the STAIY2 scale and the perceived importance of various tasks, both before and after psychiatric intervention.

Table 21. STAIY2 sores and Importance of Tasks before and after the Psychiatric Intervention (Diagnosed with Anxiety Disorder, Pearson’s r).

Activities	Before	After
Personal Hygiene/Grooming	$r(68) = -0.156, p = 0.203$	$r(68) = -0.308, p = 0.011$
Bathing/Showering	$r(68) = -0.139, p = 0.258$	$r(68) = -0.334, p = 0.005$
Dressing	$r(68) = -0.091, p = 0.458$	$r(68) = -0.246, p = 0.043$
Sexual Activity	$r(68) = -0.204, p = 0.095$	$r(68) = -0.300, p = 0.013$
Care for Others	$r(68) = -0.244, p = 0.045$	$r(68) = 0.108, p = 0.381$
Driving/Using Public Transport	$r(68) = -0.329, p = 0.006$	$r(68) = -0.125, p = 0.310$
Emergency Handling	$r(68) = -0.119, p = 0.332$	$r(68) = -0.290, p = 0.017$
Shopping	$r(68) = -0.302, p = 0.012$	$r(68) = -0.221, p = 0.071$
Job Search	$r(68) = -0.143, p = 0.246$	$r(66) = -0.284, p = 0.021$
Paid or Unpaid Work	$r(67) = -0.224, p = 0.068$	$r(64) = -0.252, p = 0.045$
Participation in Leisure Activities	$r(68) = -0.309, p = 0.010$	$r(68) = -0.264, p = 0.029$
Participation in Community Activities	$r(68) = -0.385, p = 0.001$	$r(68) = -0.112, p = 0.363$
Participation in Family Activities	$r(68) = -0.299, p = 0.013$	$r(68) = -0.268, p = 0.027$
Participation in Activities with Friends	$r(68) = -0.340, p = 0.047$	$r(68) = -0.150, p = 0.223$

Before Psychiatric Intervention:

The STAIY2 scale exhibited a significant moderate negative correlation with the perceived importance of several tasks. Specifically, higher anxiety levels were associated with reduced importance placed on “Driving/Using Public Transportation” ($r(68) = -0.329, p = 0.006$), “Shopping” ($r(68) = -0.302, p = 0.012$), “Participation in Leisure Activities” ($r(68) = -0.309, p = 0.010$), “Participation in Community Activities” ($r(64) = -0.385, p = 0.001$), and “Participation in Activities with Friends” ($r(63) = -0.340, p = 0.047$). This indicates that individuals with higher anxiety perceived these tasks as less important.

Furthermore, the STAIY2 scale shows a significant weak negative correlation with the importance of “Care for Others” ($r(68) = -0.244, p = 0.045$) and “Participation in Family Activities” ($r(68) = -0.299, p = 0.013$), suggesting a modest influence of anxiety on the perceived importance of these tasks.

After Psychiatric Intervention:

Post-intervention, the STAIY2 scale maintained a significant moderate negative correlation with the perceived importance of several tasks. Higher anxiety levels were associated with decreased importance of “Personal Hygiene/Grooming” ($r(68) = -0.308, p = 0.011$), “Bathing/Showering” ($r(68) = -0.334, p = 0.005$), and “Sexual Activity” ($r(68) = -0.300, p = 0.013$). This indicates that anxiety continued to impact the perceived importance of these tasks even after psychiatric intervention.

Moreover, the STAIY2 scale showed a significant weak negative correlation with the importance of “Clothing” ($r(68) = -0.246, p = 0.043$), “Handling Emergencies” ($r(68) = -0.290, p = 0.017$), “Job Search” ($r(66) = -0.284, p = 0.021$), “Paid or Unpaid Work” ($r(64) = -0.252, p = 0.045$), “Participation in Leisure Activities” ($r(68) = -0.264, p = 0.029$), and “Participation in Family Activities” ($r(68) = -0.268, p = 0.027$). These findings indicate that anxiety continued to negatively influence the perceived importance of these tasks following intervention, though the correlations were weaker compared with the pre-intervention period.

As presented in Table 22, the Pearson’s correlation coefficient analysis revealed several significant associations between the Zung scale and the perceived importance of various tasks, both before and after psychiatric intervention.

Table 22. Zung scale scores and Importance of Tasks before and after the psychiatric intervention (Diagnosed with Major Depressive Disorder, Pearson’s r).

Activities	Before	After
Sexual Activity	$r(34) = -0.134, p = 0.449$	$r(33) = -0.360, p = 0.039$
Emergency Handling	$r(34) = -0.386, p = 0.024$	$r(34) = -0.216, p = 0.221$
Meal Preparation and Cleanup	$r(34) = -0.340, p = 0.049$	$r(34) = -0.289, p = 0.098$
Participation in Leisure Activities	$r(34) = -0.268, p = 0.125$	$r(34) = -0.467, p = 0.005$
Participation in Community Activities	$r(34) = -0.191, p = 0.279$	$r(34) = -0.433, p = 0.010$
Participation in Family Activities	$r(34) = -0.220, p = 0.047$	$r(34) = -0.106, p = 0.552$
Participation in Activities with Friends	$r(34) = -0.180, p = 0.308$	$r(34) = -0.406, p = 0.017$

Before Psychiatric Intervention:

The Zung scale exhibited a significant moderate negative correlation with the perceived importance of certain tasks. Specifically, higher levels of depression, as measured by the Zung scale, were associated with a decreased importance placed on “Handling Emergencies” ($r(34) = -0.386, p = 0.024$) and “Meal Preparation and Space Restoration” ($r(34) = -0.340, p = 0.049$). This suggests that individuals with higher depression scores tended to perceive these tasks as less important.

Similarly, the Zung scale showed a significant weak negative correlation with the importance of “Participation in Family Activities” ($r(34) = -0.220, p = 0.047$), indicating a slight decrease in the perceived importance of these activities among individuals with higher depression levels.

After Psychiatric Intervention:

Post-intervention, the Zung scale maintained a significant moderate negative correlation with the importance of several tasks. Depression levels were significantly associated with reduced importance of “Sexual Activity” ($r(33) = -0.360, p = 0.039$), “Participation in Leisure Activities” ($r(34) = -0.467, p = 0.005$), “Participation in Community Activities” ($r(34) = -0.433, p = 0.010$), and “Participation in Activities with Friends” ($r(34) = -0.406, p = 0.017$). These findings indicate that, even after psychiatric intervention, higher depression scores continued to negatively influence the perceived importance of these tasks.

4. Discussion

This study revealed that psychiatric interventions, including pharmacotherapy, psychotherapy, or a combination of both, significantly improved occupational functioning among patients with major depressive disorder (MDD) and anxiety disorder (AD). Based on the review of the existing literature, this is the first time that the impact of psychiatric therapeutic interventions on specific task domains in patients with MDD and AD has been examined from an occupational science perspective. Most studies have focused on the impact of psychiatric therapies on the overall functionality of these patients. By analyzing the profile and task balance of patients, rather than exclusively their functionality, we explore the need for developing interventions that target specific areas of occupational

dysfunction. This also underscores the importance of an interdisciplinary team approach in the management of these disorders.

However, these findings are consistent with the existing literature that has explored the impacts of exposure-based therapies for AD. Heining found that these therapies significantly enhanced social and physical activity levels in patients, which aligns closely with the improvements in daily activity impairments observed in the present research [39]. Both studies underscore the therapeutic potential of interventions that directly target anxiety symptoms through exposure and gradual desensitisation. Heinig's work specifically showed that patients who underwent exposure therapy reported higher levels of engagement in social activities and physical exercise, indicating an overall enhancement in their quality of life [40]. Results stated by Lochner also support these findings by demonstrating that effective treatment of AD can lead to improved quality of life, though they primarily focused on general life satisfaction and functional outcomes rather than specific occupational tasks [40]. These findings support the notion that reducing anxiety through structured therapeutic exposure can lead to broader improvements in daily functioning and activity engagement, reinforcing the results from the present study on the positive effects of psychiatric interventions.

The practical implications of this study suggest that improving occupational functioning should be key in the treatment of MDD and AD. This aligns with a growing recognition in the field that mental health interventions should extend beyond symptom management to address broader aspects of life functioning and quality of life and the need for an integrated approach to mental health treatment [41]. Thus, future research could explore the synergistic effects of combining biologically informed treatments with traditional therapeutic approaches, aiming to optimize both symptom reduction and functional recovery.

This research also found that effective psychiatric interventions can lead to substantial improvements in daily functioning and occupational performance. Similarly, Barge-Schaapveld reported that depressed individuals exhibited lower levels of positive mood and enjoyment of activities compared with healthy individuals [42]. They highlighted that depressed subjects experienced more frequent and severe physical complaints and negative mood states, which correlated with lower momentary quality of life (mQoL). This aligns with findings in this research that interventions targeting these symptoms can improve overall functional outcomes. Findings from a scoping review on rehabilitation pharmacotherapy and from this study collectively indicate that while antidepressant monotherapy can lead to significant improvements in quality of life for patients with MDD, a comprehensive treatment approach that includes both pharmacological and psychotherapeutic interventions is likely more effective in addressing the full spectrum of functional impairments, including those related to occupational roles and cognitive deficits [43].

Jha explored how antidepressant treatment impacted nonwork-related activity impairments in patients with MDD, with a particular focus on the role of age. Their study revealed that younger patients reported greater improvements in task difficulty and importance post-treatment compared to older patients [44]. This finding parallels the observation of a weak positive relationship between age and increased difficulty in personal hygiene and caring for others in the present research. Both studies suggest that age is an important factor to consider when assessing the efficacy of psychiatric interventions. Jha proposed that younger patients might benefit more from certain types of interventions, which may require modifications to treatment approaches for older populations to achieve similar levels of improvement. Findings of this study support this by indicating that older patients might need more tailored interventions to overcome specific daily activity impairments.

Both the present study and the meta-analysis by Kamenov emphasize the importance of holistic treatment approaches for MDD, particularly the combined use of pharmacotherapy and psychotherapy to improve not only symptoms, but overall functioning and quality of life [45]. Both studies underscore that addressing daily functionality and broader life domains is crucial for achieving long-term clinical success in depression treatment. The alignment in their findings reinforces the idea that integrated treatment strategies are generally

more effective in enhancing patient outcomes, advocating for personalized approaches that consider individual factors such as age to maximize the benefits of depression interventions.

Both the present research and the research by Kolovos underscore the effectiveness of their respective treatments—pharmacotherapy and psychotherapy—in managing MDD, particularly in improving depressive symptoms and enhancing patient outcomes [46]. The studies align in recognizing that these treatments significantly contribute to better daily functioning and quality of life. Together, they advocate for an integrated treatment approach that combines both therapies to maximize the overall well-being and life quality of patients with depression.

The research on evaluating the efficacy of psychiatric interventions on occupational dysfunction in MDD and AD patients offers valuable insights into how these interventions can enhance occupational functioning and daily activities in individuals with these conditions. By integrating findings from related studies, this research highlights the necessity of a comprehensive, multidisciplinary treatment approach that not only targets psychiatric symptoms, but also addresses functional impairments. These insights are crucial for advancing mental health treatment strategies, ultimately aiming to improve the quality of life for individuals affected by MDD and AD.

Future research should explore several areas to build upon the findings of this study. Firstly, there is a need for long-term studies to assess the sustainability of improvements in occupational functioning among MDD and AD patients following psychiatric interventions. Additionally, research should investigate the differential impacts of various therapeutic modalities, including emerging digital and telehealth interventions, on occupational outcomes. Furthermore, studies that examine the role of comorbid conditions and their effect on treatment efficacy could provide valuable insights for developing more personalized and integrated treatment approaches [40,42]. Expanding the research to include diverse populations across different cultural contexts would also enhance the generalizability of the findings. Finally, exploring the mechanisms through which psychiatric interventions impact specific areas of occupational dysfunction could guide the development of targeted therapeutic strategies. These strategies should focus on addressing distinct areas of dysfunction, such as personal care, social participation, or work-related activities, and emphasize the need for an interdisciplinary team approach to improve functional outcomes in patients with MDD and AD.

5. Conclusions

Psychiatric interventions led to a substantial reduction in the perceived difficulty of occupational tasks after treatment. Patients reported notable improvements in their ability to perform daily activities, including personal hygiene/grooming, bathing/showering, dressing, physical activity, sexual activity, health management, shopping, rest, sleep preparation, participation in sleep, job seeking, paid or unpaid work, participation in volunteer activities, participation in leisure activities, and participation in community and family activities and activities with friends. These results highlight the effectiveness of psychiatric treatments in enhancing occupational functioning and reducing the overall burden of illness on daily life.

This study found a significant increase in patients' willingness to communicate about their mental health status following psychiatric intervention. This included openness about their mental illness, psychiatric consultations, medication use, and engagement in psychotherapy. Such transparency is crucial for reducing stigma and improving social support, which are essential components of successful long-term management of mental health conditions. In addition, the research indicated that demographic factors, such as the absence of children, played a significant role in the perceived difficulty of certain tasks post-intervention.

The study identified a significant, though weak, relationship between age and changes in task difficulty and importance, as older patients reported a greater reduction in the importance of tasks such as personal hygiene and participation in voluntary activities.

This finding underscores the necessity for age-specific psychiatric interventions to address the unique needs of different age groups. Furthermore, the Pearson's correlation coefficient analysis revealed distinct patterns in the relationship between anxiety and depression levels, as measured by the STAIY1, STAY2, and Zung scales, and the perceived difficulty and importance of various tasks both before and after psychiatric intervention. These results align with contemporary theories suggesting that comprehensive treatment strategies, encompassing both pharmacological and psychotherapeutic approaches, are essential for effectively managing MDD and AD. Despite the positive outcomes, some residual symptoms remained, indicating the need for continued research into more targeted treatment modalities.

This study demonstrates the significant positive impact of psychiatric interventions on occupational functioning in patients with MDD and AD. The findings support the development of integrated, personalized treatment plans that consider individual demographic factors and the importance of reducing stigma through increased communication about mental health. Future research should focus on refining interventions that are specifically tailored to dysfunctional areas of occupational performance, emphasizing the importance of an interdisciplinary team approach in managing these disorders, in order to further enhance patient outcomes and quality of life.

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