Evaluating “Livsdesigneren”: An Occupational Therapy Intervention for Stress Reduction

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Background: Stress affects 28% of the European workforce, posing severe health and economic challenges. Despite existing interventions, the multidimensional nature of stress remains inadequately addressed. **Aim:** This study aimed to: (a) assess whether participants experiencing stress perceived reduction in stress and enhancement in well-being through planning, prioritizing, and adjusting daily occupations, and (b) explore the participants' experiences with the program. **Material and Methods:** A mixed method with a convergent parallel design was conducted. Two groups were included: a Working Group, (WG) and a Non-Working Group, (NWG). Stress levels were measured using Cohen's 10-item Perceived Stress Scale, and well-being using World Health Organization-Five Well-Being Index. Qualitative interviews and a Content Validity Index questionnaire provided in-depth insights. **Results:** Over time, WG: seven out of nine participants achieved significant stress reductions, and seven out of nine demonstrated significant increases in well-being. NWG: two out of seven achieved significant stress reduction, while five out of seven demonstrated significant increases in well-being. Qualitative data revealed that participants valued the structured, occupation-oriented approach, highlighting, planning, insights, empowerment and regaining meaningful occupations as key outcomes. **Conclusions:** The LD program showed promising results in reducing stress and improving well-being for the WG, while the NWG demonstrated greater variability.

Keywords: daily occupations; individual; occupational balance; stress management; well-being.

Introduction

Stress is a global challenge, with 28% of people in Europe experiencing work-related stress. Consequently, stress ranks as the second most common work-related health problem (1). In Denmark, the National Research Centre for the Working Environment estimates that stress imposes a financial burden of at least 16.4 billion DKK annually on workplaces. Moreover, stress prevalence is increasing, as evidenced by an 8.5% rise in the number of Danes with high stress scores between 2010 and 2021 (2). The National Health Profile from 2021 states that 29,1% of Danes reported high stress score measured by Cohen's 10-item Perceived Stress Scale (PSS-10) (3).

Stress stems from both work and personal life (4). Chronic stress is not considered a disease in itself, however is classified in the ICD-11 as "QE01: Stress, not elsewhere classified," without further description (5). Stress manifests with physical, psychological, and behavioural symptoms. Physical symptoms often include headaches, heart palpitations, chest tightness, dizziness, and abdominal pain (6). Stress can induce psychological symptoms so severe that they resemble those of a cerebral injury. The most common symptoms include exhaustion, inner restlessness, memory and concentration difficulties, low self-esteem, and an overwhelming sense of inability to cope (6). Stress constitutes an increased risk factor for a range of diseases (7), where prolonged exposure to stress is known to lead to severe health consequences, including hypertension, cardiovascular disease, depression, and worsened prognoses for pre-existing conditions (3). Additionally, stress can lead to behavioural problems such as insomnia, rumination, loss of perspective, indecisiveness, and increased absenteeism due to illness (6). Individuals with high levels of stress can exhibit behaviour that creates obstacles and undermines their job performance, and may occur more unfocused, less effective and spends more time in off-task behaviour (8). Moreover,

individuals experiencing high stress often find it difficult to alter their circumstances, leaving them trapped in a negative cycle (8).

Existing interventions targeting psychological and mental factors – such as mindfulness (9), flow (10), gratitude interventions (11), and cognitive behavioural therapy (12) have shown positive outcomes in stress reduction. However, these interventions are often limited in the effects. For instance, mindfulness might not have a protective effect against stress if a person experiences high levels of emotional challenges (13). Similarly, as stress impairs the experience of flow, which may prevent individuals with high stress levels from deriving the same benefits of being in flow as those with lower stress levels (10). Although practicing gratitude might reduce stress, it does not enhance the sense of meaning of life (14), being highlighted as essential for well-being (15). Furthermore, as these interventions only focus on single factors, they may not, as recommended by Netterstrøm, fully address the multidimensional elements of stress as predictability, meaning, energy balance, and time management, which is essential for effective stress management (6). Therefore, the current treatments offered to people with stress seems to be insufficient.

Since stress arises as a response to strain, effective interventions must focus on balancing life demands with the individual person's resources and equipping the person with skills for planning and managing daily occupations. As understanding the complex aspects of occupations is a core competence of occupational therapists (OT's), using models from the OT repertoire, being designed to support the OT's in understanding how occupational and situational elements dynamically influence each other, is recommended. This could be the intertwined elements from the "Transactional Model of Occupation" (TMO) from which an understanding and approach the occupational life of person with stress may derive (16).

Structure and prioritization are fundamental components of stress management (6) and is one of the therapeutic strategies used by OT's to provide clients with a sense of control and security by highlighting opportunities and barriers (17). Additionally, minimizing stress-triggering situations through environmental adjustments tailored to the individual's needs is another key to be played (6). OT's apply activity analysis to assess and adapt the complexity, flexibility, and demands of occupations to create an optimal match between the individual, the activity, and the environment (18) (19).

Despite the seemingly alignment between the OTs' competencies and stress management, few studies have examined the application of OT in this area. In a 2023 scoping review only eight studies on OT group interventions treating stress were identified with just three addressing individual interventions. Of these, two were conducted in military contexts, and one focused on photo-assisted discussions related to well-being (20). Therefore, to address the complexity in stress using OT models and approaches to enable a manageable occupational life and heighten people with stress' wellbeing, an individual OT program called Livsdesigneren [in English: "The Life Designer"] (LD) was developed.

This study aimed to: (a) assess whether participants experiencing stress perceived reduction in stress and enhancement in well-being through planning, prioritizing, and adjusting daily occupations, and (b) explore the participants' experiences with the LD program.

Material and Methods

Design

To fulfil the aims, the study is conducted as a pilot study, applying a mixed method approach with a convergent parallel design (21). This design enabled the collection of

both quantitative and qualitative data within the same phase, allowing for separate analysis of each dataset before merging them to interpret the findings (22).

Participants

To evaluate the LD program, two distinct groups participated in the program. The Working Group (WG) consisted of persons connected to the labour market, where stress was seen as the primary condition. The Non-Working Group (NWG) consisted of individuals with limited resources and no connection to the labour market, where stress was a secondary condition resulting from either physical or mental illness. The two target groups represent a broader perspective on stress, as they are potentially exposed to different types of stressors. The WG may primarily experience strain related to workload, deadlines, work relationships, and work-life balance, whereas the NWG may be more significantly affected by illness, unemployment, loss of agency, financial insecurity, and other social factors. Including both groups allows for a more nuanced understanding of the role of meaningful occupations in stress management.

1: WG:

Inclusion Criteria	Exclusion Criteria
A stress-score +17 measured on PSS-10 Employed or connected to the labour market within the last three months. The participant identifies stress as primary condition	Mental illness with mood fluctuations, such as borderline personality disorder and bipolar disorder.

A convenience sample (21) was recruited via the social media platform LinkedIn. Potential participants were directed to a website containing detailed information about the study and a contact form. Subsequently, the first author contacted participants by

telephone to provide additional information about the study procedures and address any questions.

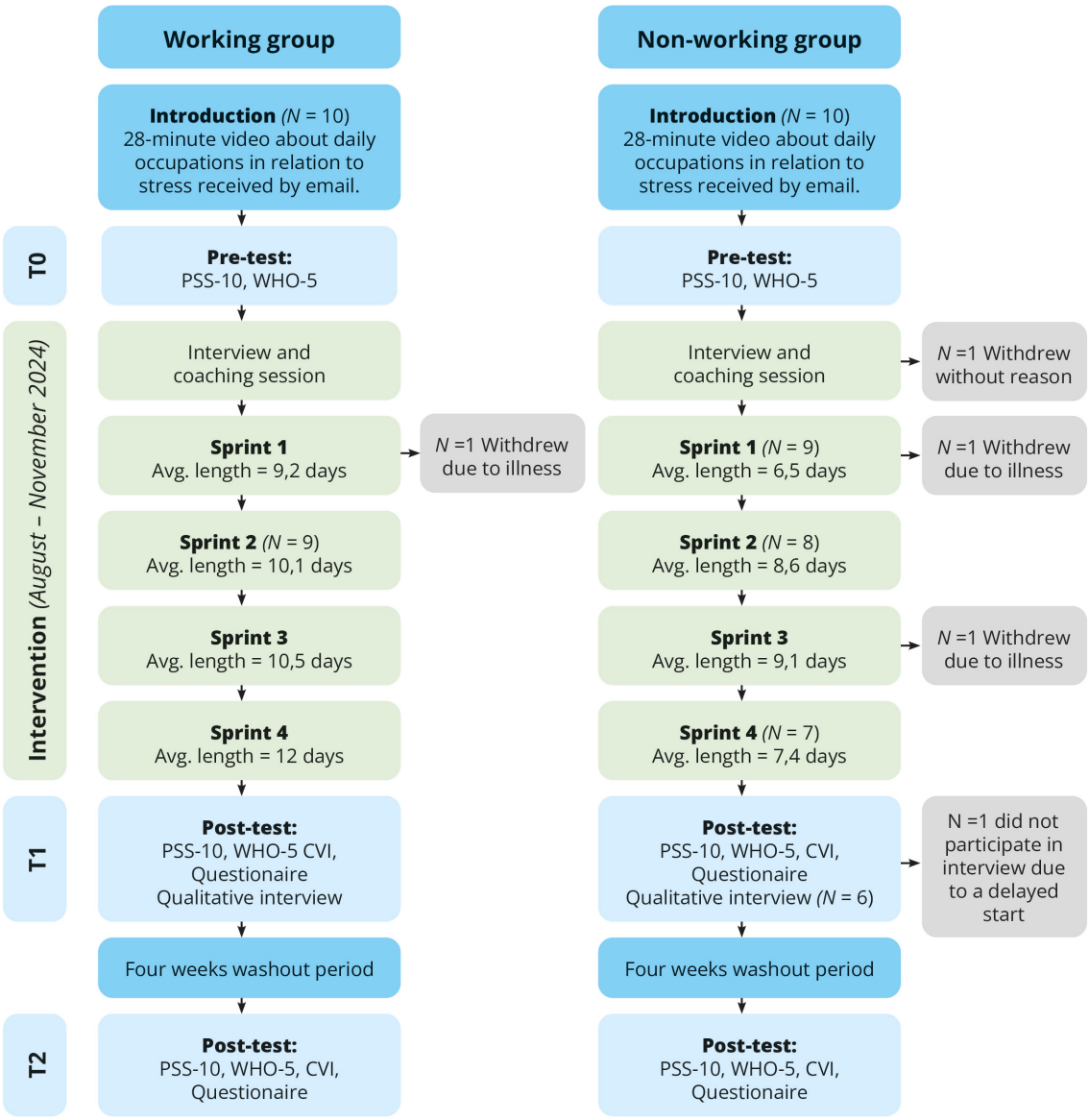
2: NWG:

Inclusion Criteria	Exclusion Criteria
A stress-score +17 measured on PSS-10 No connection to the labour market within the last two years Mental or physical illness with stress as derived condition	Mental illness with mood fluctuations, such as borderline personality disorder and bipolar disorder.

A convenience sample was recruited through a social enterprise dedicated to supporting unemployed individuals in vulnerable positions return to work or education. Among the NWG participants, stress was primarily attributed to underlying mental health conditions, including anxiety, PTSD, autism, ADHD and schizophrenia, with several participants presenting multiple diagnoses. The first author conducted in-person meetings with potential participants at the social enterprise to provide detailed information about the study procedures.

Overview of the study

Figure 1. Overview of the study



Note. T0 = Baseline. T1 = Post intervention. T2 = Post washout period. PSS-10 = Cohen's 10-item Perceived Stress Scale. WHO-5 = World Health Organization-Five Well-Being Index. Avg = Average

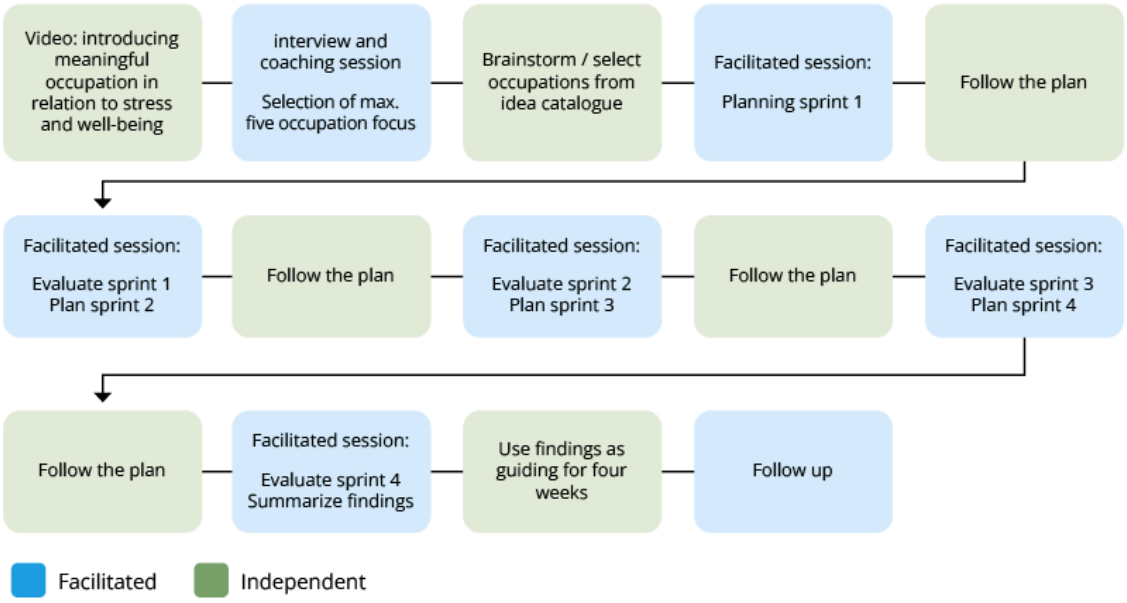
The LD program

The intent of LD is to optimize daily life for people experiencing high levels of stress by leveraging the therapeutic potential of daily occupations. The LD program was developed through four quality improvement cycles, during which it was tested and adjusted based on feedback prior to this study.

The LD program is an individual intervention between an occupational therapist and a client comprising: (a) an initial start containing an interview and a coaching

session, (b) four facilitated sessions, during which participants discuss and refine specific occupations from the previous sprint, (c) an end containing an analysis of the client's identified occupational patterns illustrating how various activities impact daily life. Based on this analysis, participants identify and prioritize occupations on a monthly, weekly, and daily basis to achieve a more balanced and sustainable daily life.

Figure 2. Overview of the LD program



The objective for the LD program is to support participants in managing daily life with stress by teaching them to intentionally plan and prioritize meaningful occupations. This is achieved through a structured process of problem-solving and reflections on daily occupations. The program facilitates this approach by equipping participants with tools to "design" an intentional and balanced life through meaningful occupations.

The program's focus on recovery through meaningful occupations is rooted in principles of occupation science, like Wilcock's perspective, which posits that health and well-being are a result of what we do, and that human development is a continuous process shaped by occupations (23).

Given the complexity of stress affecting personal and professional domains (24), the LD program addresses these dimensions through 12 distinct life domains and 36 occupational focuses. Lastly the black hole represents the time that are neither planned nor intentionally used.

Figure 3. The 12 Life Domains

The LD program's four phases, referred to as "sprints", contains a meeting of client and therapist. Each sprint begins with the client reflecting on the previous sprint/week, during which he or she evaluate their experiences and outcomes. Based on these reflections, occupations for the subsequent sprint are planned. The duration of each sprint is flexible, ranging from one to four weeks, depending on the participant's preference for testing the occupational composition and assessing its effects.

The program includes a physical workbook that structures the facilitation sessions. For each sprint, the client collaborates with the occupational therapist on the following steps, which are documented in the client's workbook:

- Evaluation of occupations from the previous sprint
- Activity analysis of the most beneficial occupation during the sprint, considering aspects such as occupational balance, well-being, joy, relaxation or reward
- Activity analysis of the least beneficial occupation, focusing on factors such as occupational imbalance, stress or exhaustion
- Activity analysis of an occupation unintentionally omitted during the sprint
- Summary of findings from the sprint
- Planning of occupations for the next sprint

To complement the workbook, participants had access to an online idea catalogue containing 377 occupation ideas distributed across 36 occupation focuses. This resource served as inspiration for planning and implementing meaningful occupations.

Instruments

Cohen's 10-item Perceived Stress Scale (PSS-10) (applicated in T0+T1+T2)

The participants' levels of stress were assessed using the Danish consensus version of the 10-item Perceived Stress Scale (PSS-10). This tool has demonstrated strong psychometric properties, including agreement, reliability, validity, responsiveness, and interpretability (25). The PSS-10 includes 10 statements designed to measure perceived stress. Items assess dimensions such as helplessness, by evaluating an individual's sense of control over their situation, emotions, or responses (e.g., In the last month, how often have you felt that you were unable to control the important things in your life?), and

self-efficacy, by evaluating an individual's confidence in managing problems (e.g., In the last month, how often have you felt confident about your ability to handle your personal problems?). Each item is rated on a five-point ordinal scale: never, almost never, sometimes, fairly often, very often. Participants completed the test online, where responses were automatically converted to numerical scores, yielding a final score ranging from 0 to 40. Higher scores indicate greater perceived stress. Within the Danish healthcare system, a PSS-10 score above 17–18 is considered concerning, while scores exceeding approximately 25 are regarded as requiring treatment (26). The minimal clinical important change (MCIC) for the PSS-10 has been estimated at 28% (25).

World Health Organization-Five Well-Being Index (WHO-5) (applicated in T0+T1+T2):

Well-being was assessed using the WHO-5, a Danish developed scale that has proven to be a highly sensitive screening tool for detecting improvements in well-being following treatment (27). WHO-5 include the following five statements, designed to measure well-being:

For the last two weeks:

(1) I have felt cheerful and in good spirits
(2) I have felt calm and relaxed
(3) I have felt active and vigorous
(4) I woke up feeling fresh and rested
(5) My daily life has been filled with things that interest me

Each item is rated on a six-point ordinal scale: all of the time = 5, most of the time = 4, more than half of the time = 3, less than half of the time = 2, some of the time = 1, at no

time = 0". The total score is calculated by summing the scores for all five items and multiplying by four, resulting in a percentage score ranging from 0 to 100. Higher scores reflect greater well-being. A score of 50 or below is considered indicative of an increased risk for stress or depression. The MCIC for the WHO-5 is estimated at 10% (28).

Questionnaire and Content Validity Index (CVI) (applicated in T1)

A questionnaire was developed to gather participants' experiences with the LD program. It consisted of 23 questions, with the first nine collecting demographic information and which life domains participants focused on throughout the intervention, as well as their perceptions of their own engagement. The remaining 12 questions comprised a CVI evaluation of specific elements of the LD program. CVI is measured on a four-point ordinal scale, with the following response options: 1 = not relevant, 2 = somewhat relevant, 3 = quite relevant, and 4 = highly relevant (29). Participants were also invited to provide qualitative comments in response to each question. The following 12 elements of the LD program were rated:

- The approach of engaging with daily life through the framework of 12 distinct life domains
- Brainstorming occupation ideas within selected occupation focuses
- Structuring the LD program into four sprints
- Weekly planning
- Daily planning
- Acceptance exercise subsequently planning
- Reflection on the occupations from the previous sprint
- Reflection on time-estimation skills

- Activity analysis of the most beneficial occupation from the previous sprint
- Activity analysis of the least beneficial occupation from the previous sprint
- Activity analysis of an occupation unintentionally omitted
- Gratitude exercise following the sprint

Data were collected using SurveyXact (30).

Qualitative interview (applicated in T1):

Following the intervention, qualitative interviews were conducted to gather in-depth insights. To strengthen trustworthiness, an external consultant conducted interviews with the WG using Microsoft Teams (31), while the NWG interviews were carried out by a consultant affiliated with the social enterprise. All interviews were recorded. Neither interviewer had prior knowledge of the results or outcomes of the intervention. All interviewers were provided with a semi-structured interview guide containing 12 open-ended questions. The interview guide was developed to cover the following topics: (a) deprivation of meaningful occupations, (b) occupation-based stress reduction, (c) structure of the LD program, (d) comparison with other services, and (e) overall experience of the LD program. The interview guide was pilot-tested (21) in two stages for clarity and relevance. First, the external consultant reviewed the guide and provided feedback on each question. Subsequently, a test interview was conducted with a participant who had previously taken part in the program. During this interview, the participant not only answered the questions but also shared their interpretation of what each question aimed to address.

Questionnaire (applicated in T2):

A follow-up questionnaire was administered to assess the extent to which participants

continued to consciously select, deselect, and adjust daily activities to create balance, as well as their ongoing engagement in planning. The questionnaire consisted of two questions:

- To what extent are you conscious of selecting, deselecting, and adjusting daily activities to create balance?
- To what extent do you plan your week?

Each rated on a four-point ordinal scale: 1 = not at all, 2 = to a low degree, 3 = to some degree, 4 = to a high degree.

Processing and analysis method(s)

Quantitative data:

Descriptive statistics were applied to PSS-10 and WHO-5 scores to illustrate baseline for the participants, as well as changes from T0 to T1 and from T0 to T2, using mean and standard deviation. Data from the CVI were analysed to calculate the Item-Content Validity Index (I-CVI), which was determined by dividing the number of participants assigning a rating of 3 or 4 by the total number of participants. For samples with more than five participants, an I-CVI of ≥0.78 indicates sufficient agreement on item relevance (29). Quantitative data were organized in a data matrix alongside results from the questionnaires. To ensure participant anonymity, all data were translated into numerical values and linked to unique ID numbers.

Qualitative data:

A qualitative content analysis was conducted to systematically and objectively describe the data (32). All interviews were recorded, transcribed, and analysed using an inductive

approach (21) following three main phases: preparation, organization and reporting (32). In the preparation phase, all interviews were transcribed by the first author using a GDPR-compliant AI transcription tool (33). The audio files were uploaded to the platform, and the transcriptions were subsequently reviewed and revised multiple times to ensure accuracy. After transcription all audio files were deleted. Transcribed interviews were read multiple times to ensure immersion in the data. In the organization phase, the transcriptions were organized into a matrix, where meaning units were identified, condensed and assigned specific codes. Once the coding process was complete, the coded segments were grouped into categories, enabling a systematic analysis of the data. Example of the matrix:

Meaning unit	**Code**	**Category**
It's given me insights into all these things I didn't notice before. They were hidden from me, so I hadn't realized they could be stressing me out or affecting how I feel (…) And looking at the week and asking, "Is this actually realistic?"	Hidden stressors	Planning and Overview

To enhance the trustworthiness of the analysis, an external consultant independently coded four transcriptions. The consultant's codings were then compared with those of the first author to ensure consistency and reliability (32).

Ethics

This study involved the collection of sensitive personal information from participants. To ensure compliance with applicable regulations for handling sensitive data, all participants received both verbal and written information about the study. Informed consent was obtained in both verbal and written form prior to data collection. All data were stored on secure servers protected by two-factor authentication. Upon completion of transcription and anonymization, all interview recordings were deleted. Similarly, quantitative data were anonymized to safeguard participant privacy. Adhering to the

Declaration of Helsinki principles, participation in the study was based on informed consent, assuring anonymity and confidentiality for each participant (34). Additionally, we followed EU's General Data Protection Regulation (GDPR) (35). Ethical approval was covered by the overall protection of the Copenhagen University College, thus further formal approval was not sought.

Results

Table 1. Sociodemographic characteristics (*n*=16)

Sociodemographic characteristics	WG *n* = 9	NWG *n* = 7	Total *n* = 16
Age			
20 – 29		1 (14.3%)	1 (6.3%)
30 – 39	3 (33.3%)	2 (28.6%)	5 (31.3%)
40 – 49	2 (22.2%)	1 (14.3%)	3 (18.8%)
50 – 59	4 (44.4%)	3 (42.9%)	7 (43.8%)
Gender			
Male	2 (22.2%)	2 (28.5%)	4 (25.0%)
Female	7 (77.7%)	5 (71.5%)	12 (75.0%)
Education			
Vocational education		1 (14.3%)	1 (6.3%)
High school		1 (14.3%)	1 (6.3%)
Bachelor's degree		3 (42.9%)	3 (18.8%)
Master's degree	8 (88.8)	2 (28.6%)	10 (62.5%)
Other	1 (11.1%)		1 (6.3%)
Number of children under 13 living at home			
0	6 (66.6%)	6 (85.7%)	12 (75.0%)
1	1 (11.1%)		1 (6.2%)
2	2 (22.2%)	1 (14.3%)	3 (18.8%)
Employment status			
Full time employment	5 (55.5%)		5 (31.2%)
Part time employment	3 (33.3%)		3 (18.7%)
On part time sick leave	1 (11.1%)		1 (6.3%)
On full time sick leave		5 (71.5%)	5 (31.3%)
Job seeking		1 (14.3%)	1 (6.3%)
Other support		1 (14.3%)	1 (6.3%)
Civil status			
Married / live-in partner	6 (66.6%)	4 (57.1%)	10 (62.5%)
In relationship, but live alone	1 (11.1%)		1 (6.3%)
Single	2 (22.2%)	3 (42.9%)	5 (31.3%)
Network			
Perceives having a supportive network	9 (100%)	6 (85.7%)	15 (93.7%)
Perceives not having a supportive network		1 (14.3%)	1 (6.3%)
Health			
Physical diagnosis(es) affect stress level	3 (33.3%)	2 (28.6%)	5 (31.3%)
Mental diagnosis(es) affect stress level	3 (33.3%)	6 (85.7%)	9 (56.3%)
A close family member has a diagnosis that affects my stress	2 (22.2%)	2 (28.6%)	4 (25.0%)
No diagnoses affect my stress	3 (33.3%)		3 (18.8%)
Events and uncertainty about the future			
Divorce. illness. accidents. or other events affect stress levels	4 (44.4%)	2 (28.6%)	6 (37.5%)
Economic or job-related uncertainty affects stress levels	4 (44.4%)	7 (100%)	11 (68.8%)
No events or uncertainties affects my stress level	3 (33.3%)		3 (18.8%)

Findings from PSS-10

A total of 16 participants completed the PSS-10 assessment at three points.

Table 2. PSS-10 results

Participant	T0	T1 (% change from T0)	T2 (% change from T0)
P1, WG	30	17 (44.33%)	22 (26.67%)
P2, WG	30	16 (46.67%)	15 (50.00%)
P3, WG	27	11 (59.26%)	13 (51.85%)
P4, WG	26	14 (46.15%)	10 (61.54%)
P5, WG	31	16 (48.39%)	19 (38.71%)
P6, WG	22	10 (54.55%)	10 (54.55%)
P8, WG	30	23 (23.33%)	19 (36.67%)
P9, WG	22	8 (63.64%)	10 (54.55%)
P10, WG	26	21 (19.23%)	20 (23.08%)
P11, NWG	34	21 (38.24%)	12 (64.71%)
P12, NWG	23	16 (30.43%)	19 (17.39%)
P13, NWG	28	22 (21.43%)	22 (21.43%)
P15, NWG	22	6 (72.73%)	19 (13.64%)
P16, NWG	23	21 (8.70%)	20 (13.04%)
P19, NWG	28	17 (39.29)	17 (39.29%)
P20, NWG	22	20 (9.09%)	16 (27.27%)

WG: At T0, the mean PSS-10 score was 27.11 (± 3.44) with seven out of nine participants scoring above 25, the threshold indicative of requiring treatment. By T1, the mean PSS-10 score had decreased to 15.11 (± 4.96) and all participants scored below 25, with a mean reduction of 44.95% (± 14.97%). Seven out of nine participants achieved reductions exceeding the MCIC threshold of 28%. Two participants did not meet this threshold. However, both reported significant external factors, including personal or psychological challenges unrelated to the intervention, which may explain why they did not achieve the intended stress reduction. By T2, one of these participants

had surpassed the PSS-10 MCIC threshold with a total change of 36.67% from T0 to T2. The other participant showed a modest improvement from 19.23% to 23.08%, remaining below the threshold. One participant experienced a decline in their PSS-10 reduction percentage decreasing from 43.33% at T1 to 26.67% at T2. During follow-up, this participant reported personal challenges unrelated to the intervention. At T2, the mean PSS-10 score was 15.33, showing a mean reduction of 43.67% (± 13.09%) from T0. Overall, all WG participants improved their PSS-10 scores from T0 to T2, with seven out of nine participants achieving reductions exceeding the MCIC threshold. Notably, all participants remained below the cutoff score of 25, while five out of nine maintained or further improved their PSS-10 scores during the washout period.

NWG: At T0, the mean PSS-10 score was 25.71 (± 4.50) with three out of seven participants scoring above 25, the threshold indicative of requiring treatment. By T1, the mean PSS-10 score had decreased to 17.57 (± 5.56), with a mean reduction of 31.41% (± 22.10%). Four out of seven participants achieved reductions exceeding the MCIC threshold of 28%. At T2, the mean PSS-10 score was 17.86 (± 3.24), with a mean reduction of 21.86% (± 18.53%). Two participants experienced declines in their PSS-10 change percentages, falling below the MCIC threshold. At follow-up, both participants reported difficulties in maintaining focus on planning meaningful occupations without the structured facilitation sessions. Overall, all NWG participants improved their PSS-10 scores from T0 to T2, and all participants managed to stay below the cutoff score for requiring treatment. However, only two out of seven participants achieved and maintained reductions exceeding the MCIC of 28%.

Findings from WHO-5

A total of 16 participants completed the WHO-5 assessment at three points.

Table 3. WHO-5 results

Participant	T0	T1 (% change from T0)	T2 (% change from T0)
P1, WG	32	60 (46.67%)	32 (0.00%)
P2, WG	32	68 (52.94%)	78 (58.97%)
P3, WG	68	64 (-6.25%)	64 (-6.25%)
P4, WG	32	68 (52.94%)	76 (57.89%)
P5, WG	20	48 (58.33%)	60 (66.67%)
P6, WG	40	52 (23.08%)	68 (41.18%)
P8, WG	20	28 (28.57%)	48 (58.33%)
P9, WG	56	72 (22.22%)	64 (12.50%)
P10, WG	32	48 (33.33%)	60 (46.67%)
P11, NWG	4	68 (94.12%)	80 (95.00%)
P12, NWG	28	36 (22.22%)	32 (12.50%)
P13, NWG	16	36 (55.56%)	28 (42.86%)
P15, NWG	56	68 (17.65%)	60 (6.67%)
P16, NWG	44	52 (15.38%)	44 (0.00%)
P19, NWG	44	60 (26.67%)	60 (26.67%)
P20, NWG	56	60 (6.67%)	68 (17.65%)

WG: At T0, the mean WHO-5 score was 36.89 (± 15.85) with seven out of nine participants scoring below 50, indicative of an increased risk for stress or depression. By T1, the mean WHO-5 score had increased to 56.44 (± 13.92) and all nine participants either met the MCIC threshold of 10% or had a baseline score of ≥ 68, considered average for the general population, with a mean increase of 34.65% (± 20.54%). By T2, the mean WHO-5 score had further increased to 61.11 (± 14.11), with a mean increase of 37.33% (± 27.85%) from T0. One participant experienced a decline in their WHO-5 score, reverting to baseline. At follow-up, this participant reported personal challenges unrelated to the intervention. Overall, eight out of nine participants either surpassed the WHO-5 MCIC of 10% or had a baseline score indicative of average

well-being (≥68). Additionally, seven out of nine participants managed to maintain or improve their WHO-5 scores during the washout period.

NWG: At T0, the mean WHO-5 score was 35.43 (± 20.06) with five out of seven participants scoring below 50, indicative of an increased risk for stress or depression. By T1, the mean WHO-5 score had increased to 54.29 (± 13.63) and six out of seven met the MCIC for WHO-5 of 10%, with a mean increase of 34.04% (± 30.64%). By T2, the mean score was 53.14 (± 19.14) with a mean increase from T0 of 28.76 % (± 32.39%). Notably, at T2 six out of seven participants either demonstrated increases in WHO-5 scores exceeding the MCIC of 10% or had baseline scores close to the average level of well-being. However, only three out of seven managed to maintain or improve their WHO-5 scores during the washout period.

Findings across PSS-10 and WHO-5

Participants in the WG demonstrated significant improvements in both stress levels (PSS-10) and well-being (WHO-5). The majority of WG achieved improvements exceeding the relevant MCIC thresholds for stress reduction and well-being, with most maintaining or further enhancing these results during the washout period. In contrast, participants in the NWG showed less pronounced improvements. A smaller proportion of NWG participants achieved and sustained improvements exceeding the MCIC thresholds for stress reduction and well-being, and several reported difficulties in maintaining these gains after the intervention concluded. Overall, the WG exhibited more stable and sustained improvements in both stress levels and well-being, while the NWG demonstrated greater variability and challenges in maintaining outcomes. However, 14 out of 16 participants showed improvements in both PSS-10 and WHO-5 scores, regardless of group affiliation.

Importantly, there was a misunderstanding among some participants regarding the flexible duration of sprints. Despite being outlined in the introductory materials and reiterated in the workbook during sprint planning, several participants with an average sprint length of one week expressed at follow-up that they would have preferred longer sprints. This lack of awareness may have negatively impacted the outcomes. Furthermore, two participants had been diagnosed with clinical depression but were not undergoing treatment. As the LD program is not designed to treat depression, this may have further influenced the results. Future research should consider including clinical depression as an exclusion criterion to mitigate this issue.

Findings from CVI

A total of 16 participants completed CVI questionnaire.

Table 4. I-CVI results

LD element	**WG**	**NWG**
The approach of engaging with daily life through the framework of 12 distinct life domains.	1.00	1.00
Brainstorming occupation ideas within selected occupation focuses	1.00	1.00
Structuring the LD program into four sprints	0.78	0.71
Weekly planning	0.78	1.00
Daily planning	0.44	0.71
Acceptance exercise subsequently planning	0.67	0.71
Reflection on the occupations from the previous sprint	1.00	1.00
Reflection on time-estimation skills	0.89	0.57
Activity analysis of the most beneficial occupation from the previous sprint	1.00	1.00
Activity analysis of the least beneficial occupation from the previous sprint	1.00	1.00
Activity analysis of an occupation unintentionally omitted	0.56	0.86

Gratitude exercise following the sprint	0.67	0.86

Six of the 12 items achieved an I-CVI score greater than 0.78 across both groups, indicating sufficient agreement on their relevance. Across both groups, agreement was reported for the framework of 12 life domains, brainstorming occupation ideas, weekly planning, reflection on occupations from the previous sprint, and activity analysis of the most and least beneficial occupations from the previous sprint. Disagreements, where only one group achieved an I-CVI score greater than 0.78, were observed for "reflection on time-estimation skills", "Activity analysis of an occupation unintentionally omitted" and "Gratitude exercise following the sprint".

Findings from qualitative interviews

A total of 15 qualitative interviews were conducted. The analysis across both groups reported similar experiences and perspectives, thus no notable differences between the two target groups were identified. The results were synthesized into five key categories: *"Planning and Overview", "New Insight", "Empowerment", "Facilitation and the Therapeutic Alliance"* and *"Regaining Meaningful Occupations".* Categories emerged from systematically coded data, with each category reaching saturation.

Table 5. Categories and codes

Planning and Overview	**New insight**	**Empowerment**	**Facilitation and the Therapeutic Alliance**	**Regaining Meaningful Occupations**
Hidden stressors	Insight into patterns created awareness	Feeling of agency	Needed help to change	Impact of deprivation of meaningful occupation
Frustrated by unexpected events	Impact of small occupations	Occupation focus made change tangible	Facilitation gave feeling of safety	Prioritizing oneself
Planning created overview	Occupation focus made change feasible	Activity analysis created new possibilities	Facilitation skills were a key factor	Meaningful occupations faded out
Planning enabled	Life domains gave	Less talk – more	Facilitation	Even small

change	awareness	action	enhanced understanding the concept	occupations mattered
Structure created peace in mind	Understanding occupations enabled positive experiences	Future-oriented approach gave hope for change	Facilitation prevented overwhelm	Focus helped regaining meaningful occupations

The coding performed by the first author was compared with that of the external consultant. Minor differences were identified, discussed, and resolved through consensus. No significant discrepancies were observed.

Table 6. Example of difference in codings of first author and the consultant

Meaning unit	**Code by first author**	**Code by consultant**	**Consensus**
And I think the consequence of deprioritizing is that I end up being more alone and having fewer joyful moments… uh… So, I see it both in terms of the garden, but also in terms of spending time with the kids, as kind of a driving force for creating happiness… and uh… peace.	Consequences of deprivation of meaningful occupations	Meaningful activities bring joy and peace.	Focus helped regaining meaningful occupations
(...) if I missed anything, it was being pushed even more between the meetings (...) from a kind of greedy approach, I wish I had invested even more in it myself, to get even greater benefits from it...	Intensity and expectations	Facilitation and self-discipline	Needed help to change

Planning and Overview

Many participants reflected on their previous schedules, recognizing them as overly ambitious and packed, which they found ultimately ineffective. Reducing commitments was often not perceived as an option, and tasks frequently required more time than anticipated. Planning was described as a foundational tool for facilitating change, as it provided participants with an overview of weekly activities and their influence on mood and stress levels. This increased awareness enabled participants to prioritize self-care, incorporate breaks during the workday, and dedicate time to family. Additionally, planning highlighted areas in need of adjustment and supported the establishment of realistic expectations. As one participant stated:

> The planning ended up becoming kind of solid platform I could stand on, which helped me set a lot of expectations that I hadn't really established before (…) getting that organized, breaking it down, and aligning expectations (…) completely removed that chaotic approach to it. (P3, WG)

New insight

All 15 participants expressed gaining new insights through the LD program. A significant realization was the impact of daily occupations on their overall well-being. Participants consistently praised the occupation-based approach as a tangible and effective method for improving daily life, reducing stress, and enhancing well-being. Furthermore, participants expressed a newfound awareness of how occupations could serve as an underutilized approach to addressing broader life domains. They also highlighted the potential of small, intentional changes to create a substantial impact:

> Basically, you're looking at some pretty big foundational building blocks of life. But then you break it down into really small steps, and you get a tool to actually start building things up (…) like, "What did that activity do for you?", "What could I do differently?", "That part didn't work?", "This part — I definitely want more of that." And that feeling of having accomplished something or done something — I can see that something's changed. (P16, NWG)

Empowerment

Most participants expressed a renewed sense of agency, and a feeling of regained control, enabling them to act despite unfavourable circumstances. While many participants acknowledged the emotional relief gained through other services, they highlighted the LD program's occupational-oriented approach as particularly effective in addressing specific challenges in their daily lives. Participants also noted that other services often failed to address core issues, as it is possible to maintain an unhealthy work-life balance, inadequate sleep patterns, and poor lifestyle habits while still

practicing mindfulness and meditation. Several participants described the shift from a solely cognitive approach to an occupation-based framework as liberating, as it provided them with practical tools they could actively engage with.

> (…) these *aha* moments from LD… it just… it feels amazing, especially when you're in a bit of a pit, you know? To realize, "Oh, there's actually something here I can act on, something I can use". Something I can actually do for myself. It's not like I just sat there whining for an hour, you know? The insights and *aha* moments I've had have been really valuable. (P8, WG)

Facilitation and the Therapeutic Alliance

Many participants described themselves as being in a vulnerable position and emphasized the importance of facilitation as a critical component of the program. Participants highlighted the value of an occupational therapist as a facilitator with both life experience and strong facilitation skills in the process. Additionally, some participants found the workbook questions challenging to answer independently and expressed gratitude for the opportunity to collaborate with a facilitator. As one participant stated:

> (…) there've been a few times where I've had to ask, "But what exactly do you mean by this?" because I need things to be super clear. And the occupational therapist has been so sweet about explaining things to me and helping me keep things on track (…) I think the occupational therapists has been really great at helping me stay focused and within the framework. P13, NWG

Regaining Meaningful Occupations

Nearly all participants reported that they had, to some extent, gradually abandoned meaningful occupations due to stress and an overwhelm. Many described this process as occurring insidiously, often without conscious awareness. Participants noted that at the time, the abandoned occupations did not seem crucial, and they were unaware of the

broader consequences. Although these daily occupations appeared insignificant initially, participants later recognized their importance in maintaining occupational balance and forming the foundation of a meaningful life. Most participants expressed that the LD program helped them recognize the value of meaningful occupations and supported their reintegration into daily life.

> A lot of people have said to me, "What do you feel like doing?" or "What did you use to enjoy?" But I just never got around to doing any of it (…) The LD program has somehow made it so clear to me that I've actually started taking myself seriously. P11, NWG

Discussion

The first aim of this study was to assess whether participants experiencing stress perceived reduction in stress and enhancement in well-being through planning, prioritizing, and adjusting daily occupations. The WG demonstrated stable and significant improvements in stress levels, with a mean PSS-10 reduction of 44.18% (± 13.45%) after the washout period, exceeding the MCIC of 28%. Similarly, the mean WHO-5 scores increased by 37.33% (± 27.85%), also exceeding the MCIC for WHO-5 of 10%. These findings suggest that occupational therapy interventions may positively impact this group by reducing perceived stress and enhancing well-being. The results align with those of the Redesigning Daily Occupations (ReDO) program, a longitudinal cohort study examining the impact of an occupation-based group intervention. While the ReDO study also targeted participants connected to the labour market, it focused exclusively on women, in contrast to the current study, which included a broader population (36).

In comparison, the NWG showed less pronounced reductions in stress, with a mean PSS-10 reduction of 21.86% (± 18.53%), which did not meet the MCIC threshold

of 28%. This may reflect the nature of the stressors faced by this group, such as physical or mental illness combined with unemployment – factors known to significantly affect mental health (37). Additionally, this group may be affected by a low degree of predictability in their lives, as their life and job situations remain unresolved. Low predictability is known to reduce comprehensibility and diminish the sense of coherence (15) which may also be reflected in the data. The National Health Profile also highlights the disproportionate stress levels among unemployed individuals, where 47.7% report high stress scores compared to 23.2% among employed individuals (3). Despite these challenges, the NWG achieved significant improvements in WHO-5 scores, with a mean increase of 28.76% (± 32.39%), exceeding the MCIC for WHO-5 of 10%. This suggests that, although their stressors may be persistent, the focus on daily occupations still has a positive impact on well-being. These findings indicate that this group may benefit from extended or more intensive interventions.

The second aim was to evaluate participants' experiences with the LD program. Qualitative data revealed that participants valued the program's structured, occupational-oriented approach, which led to increased planning, new insights, empowerment, and regaining meaningful occupations. These reflections align with findings from a study conducted among patients with coronary heart disease risk factors, which found that collaborative specific action plans had a significant impact on promoting healthy behaviour change (38). Additionally, the ValMO model supports the connection between occupational value, perceived meaning, and subjective health, reinforcing the LD program's emphasis on daily occupations (39). Participants highlighted the role of structured weekly planning in managing stress by helping them identify triggers and set realistic goals for self-care and work-life balance. This finding aligns with recommendations from Netterstrøm, who emphasizes the importance of

structure and prioritization as essential strategies in stress management (6). The significance of planning is further supported by I-CVI scores of 0.78 and 1.00 for "weekly planning". Furthermore, participants identified analysing occupational patterns as a critical tool for stress management. This reflects findings from the ReDO program, which also included understanding and adjusting daily occupational patterns as part of stress management (36). The LD program's focus on occupational analysis is was praised in the qualitative data, which is supported by I-CVI scores of 1.0 for "reflection on occupations," "activity analysis of the most beneficial occupation," and "activity analysis of the least beneficial occupation". These results suggest that structured planning and occupational analysis (as evidenced in both the LD and ReDO programs), are integral components in reducing stress and improving well-being. Unlike the ReDO program, the LD program's individualized approach enabled participants to address personal challenges tailored to their unique circumstances. The diversity in participants' chosen life domains, spanning 36 occupational focuses, underscores that no single occupation focus is universally effective. This individualized methodology may have empowered participants by giving them control over their own process, which qualitative data described as "liberating" and contributing to a "renewed sense of agency". The 12 life domains framework, which also received an I-CVI score of 1.0 across both groups, further supported this approach by helping participants reflect on and identify areas with the greatest potential for stress reduction.

Discrepancies in I-CVI scores may reflect the differing life circumstances between the two groups. For example, "reflection on time-estimation skills" received an I-CVI score of 0.89 from the WG and 0.57 from the NWG, potentially highlighting the WG's scarcity of time and their greater need for this skill. Conversely, "activity analysis of an occupation unintentionally omitted" only received a I-CVI score greater than 0.78

from the NWG which may indicate that participants in the NWG experienced greater difficulty adhering to the plan, making this component particularly beneficial by providing an opportunity to reflect on and learn from unintentional deviations. The "gratitude exercise following the sprint" also showed a notable difference, with only the NWG achieving an I-CVI score above 0.78. This may suggest that the NWG had a greater need to focus on cultivating gratitude for small, positive aspects of their daily lives. Two elements received I-CVI scores below 0.78 from both groups: "Daily planning" and "Acceptance exercise prior to planning." Daily planning may have been perceived as overwhelming, time-consuming, and overly rigid. Similarly, the acceptance exercise may have appeared redundant, as most reflections during the facilitated sessions naturally focused on this area. Based on these findings, it is worth considering to exclude these elements in future iterations of the LD program.

Methodological considerations

A convergent, parallel mixed methods design was applied to fulfil the aims of the study. This approach was chosen for its ability to provide a comprehensive understanding of the research objectives by integrating complementary data within the same topic to gain deeper insights into the phenomenon (22). This study utilized the strengths of quantitative data, including measures of stress levels and well-being, alongside CVI data, while qualitative interviews provided a nuanced understanding of participants' experiences with the program. By integrating these data sources, the study offered valuable insights into the influence of various components of the LD program on perceived stress reduction and increased well-being.

The first aim was to measure stress reduction and increased well-being post intervention. To strengthen the validity, validated instruments were chosen to measure reduction in stress and increased well-being. The PSS-10, a widely recognized and

reliable instrument for measuring stress levels were chosen to measure stress reduction. The instrument comes with a threshold for percentage of minimal clinical important change indicating significant improvements. The PSS-10 was supplemented with the WHO-5, a validated and highly sensitive tool for detecting improvements in well-being following treatment, also with a threshold indicating significant improvements. Using these instruments therefor strengthened the validity and reliability of the study. Objectivity was sought by involving an external consultant. While the study's relatively small sample size and convenience sampling limit generalizability, the mixed-methods approach allowed for triangulation, revealing positive trends from both datasets which suggest that the LD program may have a positive effect in reducing stress and enhancing well-being. However, further research is needed to confirm these findings.

The second aim was to explore the participants' experiences with the LD program. To strengthen validity, CVI was adapted to evaluate specific elements of the LD program. This approach offered a quantifiable measure of consensus, enabling a deeper understanding of which elements participants deemed most impactful. To ensure trustworthiness of the qualitative data, a careful consideration was given to all three phases of the content analysis (32). In the preparation phase, a semi-structured interview guide was developed and pilot-tested in two stages, incorporating feedback from both an external consultant and a former participant. All interviews in the WG were conducted by an external consultant specializing in interview techniques, while interviews in the NWG were carried out by a consultant affiliated with the social enterprise. These measures minimized bias and enhanced credibility. During the organization phase, trustworthiness was further strengthened by independent coding of four transcriptions by an external consultant. The coding was compared with that of the first author to ensure consistency and enhance confirmability. All categories were

collaboratively aligned with the external consultant, ensuring they accurately reflected participants' voices. In the reporting phase, transparency was maintained by outlining the content analysis process in detail. To demonstrate the richness of the data and agreement among participants, no individual participant was quoted more than once.

The integration of CVI with qualitative data further enriched the analysis, allowing for a nuanced exploration of key program components and their role in achieving outcomes.

However, several limitations of this study must be acknowledged. First, the lack of a control group and the relatively small sample size, obtained through convenience sampling, limit the generalizability of the findings.

Conclusion

This study suggests that the LD program positively influenced the reduction of perceived stress and the enhancement of well-being for a group of 16 participants. Quantitative data indicated that participants across both groups demonstrated improvements in both PSS-10 and WHO-5 scores, with the majority exceeding the MCIC thresholds following the intervention. Notably, the findings suggest that the role of meaningful occupations in stress management has a positive impact across diverse stressors and life circumstances, as reflected by the fact that 14 out of 16 participants showed improvements in both PSS-10 and WHO-5 scores, regardless of group affiliation. However, the data highlight a potential need for extended intervention in the NWG to support sustained outcomes. Furthermore, the program should not be viewed as a substitute for addressing psychological challenges but rather as a complementary approach to achieving balance and effectively managing daily occupations and energy. Future research with randomized sampling and control groups is recommended to validate these findings and explore the long-term sustainability of the program's

outcomes.

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