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PERCEPTIONS AND PRACTICES OF OCCUPATIONAL THERAPISTS IN DETERMINING WORK CAPACITY OF EMPLOYEES SUFFERING FROM MAJOR DEPRESSIVE DISORDER

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DECLARATION

I, Enos Morankoana Ramano, hereby declare that the work on which this dissertation is based, is original (except where acknowledgement indicates otherwise) and it has not been previously submitted for any other degree at another University.

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SUMMARY

Keywords:

Major depressive disorder
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Practices of occupational therapists

Major depressive disorder (MDD) is a relevant condition to consider regarding Work Capacity Evaluation (WCE) because of its high prevalence, strong impact on short-term work disability, and low rate of treatment. The challenge that faces occupational therapists (OTs) is that there is no specific guideline and process to follow when conducting Work Capacity Evaluation with clients suffering from MDD. The researcher had also noted conflicting opinions with regard to the outcome of Work Capacity Evaluation (WCE) and recommendations in occupational therapy reports. The researcher is of the opinion that indeed occupational therapy assessments need to be clear about what to measure, and selection of appropriate standardised measures and non-standardised assessments is needed. Therefore, the research question was, what are the perceptions and practices of occupational therapists in determining work capacity of employees suffering from major depressive disorder?

The aim of this study was to describe the perceptions and practices of occupational therapists in determining work capacity of employees suffering from major depressive disorder. The literature showed that Work Capacity Evaluation assists to determine the employeeôs return-to-work. The Code of Good Practice: Dismissal contained in the Labour Relations Act of 1998, stipulates that incapacity on the ground of ill health or injury may be either temporary or permanent.

The nature of this study was a mixed method design including both qualitative and quantitative approaches. The phenomenological strategy was used. The study had a sample size of 68 participants, practising as occupational therapists. Purposive sampling was used. The data were collected in four distinct phases, referred to as sequential exploratory strategy

with elements of embedded design. Phase one, used descriptive open-ended questions; phase two was a close-ended questionnaire to confirm findings in phase one; phase three consisted of focus group interviews and phase four was member checking to confirm findings in phase three.

During data analysis, five themes related to employees suffering from MDD emerged and they were identified as: (1) the content of comprehensive assessment for work capacity evaluation, (2) the process of work capacity evaluation, (3) the competency requirements of the occupational therapist, (4) occupational performance and (5) formulating return-to-work decision.

Recommendations related to the five themes were formulated and suggestions for future research proffered. The study clarified and confirmed that occupational therapists have a major role to play in performing work capacity of employees suffering from major depressive disorder, and that they need to be competent in performing these evaluations.

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ACRONYMS USED

ADA	Americans with Disabilities Act
ADL	Activities of Daily Living
AMPS	Assessment of Motor and Process Skills
BADL	Basic Activities of Daily Living
BaFPE	Bay Area Functional Performance Evaluation
BDI	Beck Depression Inventory
BTE	Baltimore Therapeutic Equipments
CAM	Cognitive Assessment of Minnesota
CGP: D	Code of Good Practice: Dismissal
COPM	Canadian Occupational Performance Measure
COTNAB	Chessington Occupational Therapy Neurological Assessment Battery
DDA	Disability Discrimination Act
DOT	Dictionary of Occupational Titles
DSM-1V-TR	Diagnostic and Statistical Manual of Mental Disorder,4th Edition, Text Revision
DTLA	Detroit Test of Learning Aptitude
EAP	Employment Assistance Program
EEA	Employment Equity Act
FCE	Functional Capacity Evaluation
GBD	Global Burden of Disease
HADS	Hospital Anxiety and Depression Scale
HPCSA	Health Professional Council of South Africa
HRM	Human Resource Manager
IADL	Instrumental Activities of Daily Living
JAMAR	Jamar Hydraulic Hand Dynamometer
JOULE®FCE	The Joule® Functional Capacity Evaluation (FCE)
LOTCA	Lowingston Occupational Therapy Cognitive Assessment
LRA	Labour Relations Act
MDD	Major Depressive Disorder
MEDUNSA	University of Limpopo (Medunsa Campus)

MHCA	Mental Health Care Act
MMSE	Mini Mental State Examination
MOCA	Model of Creative Ability
MODAPTS	Modular Arrangement of Pre-determined Time Standards
MOHO	Model of Human Occupation
OCARIS	Occupational Case Analysis and Rating Scale
OT	Occupational Therapist
OTASA	Occupational Therapy Association of South Africa
PADL	Personal Activities of Daily Living
PCE	Physical Capacity Evaluation
PD	Personality Disorder
POTS	Psychiatric Occupational Therapy Support Group
PTSD	Post Traumatic Stress Disorder
RA	Reasonable accommodation
RTW	Return-to-work
SA	South Africa
SIGECAPS	Sleep, interest, guilt, energy, concentration, appetite, psychomotor, suicide.
T/PAL	Therapist Portable Skills Assessment Laboratory
TVPS	Test of Visual Perceptual Skills 3rd Edition
UCT	University of Cape Town
UFS	University of Free State
UP	University of Pretoria
USA	United States of America
VAS	Visual Analogue Scale
VCWS	Valpar Component Work Sample
VMI	Developmental Test of Visual Motor Integration 5th Edition
VR	Vocational rehabilitation
WASP	Work Ability Screening Profile
WCE	Work Capacity Evaluation
WITS	University of Witwatersrand

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CHAPTER 1

RESEARCH ORIENTATION

1.1 Introduction

Work Capacity Evaluation is defined as ña comprehensive process that systematically uses work, real or simulated, to assess and measure an individualôs physical abilities to workò[1] (p.340) not ignoring their mental abilities. Functional Capacity Evaluation (FCE)[1-4], Physical Capacity Evaluation (PCE)[1], Work Capacity Evaluation (WCE)[1,3,5-7] and Functional Capacity Assessment (FCA)[1] are terms that have been used interchangeably with reference to work assessment in return-to-work programs. ñFunctional Capacity Evaluation is the broad umbrella term applied to work assessment and can be delineated into PCE and WCEò[1] (p.339).

Work Capacity Evaluation considers interests, aptitudes, and vocational skills as secondary evaluation factors[1,8]. Primary evaluation factors are those that comprise general work ability, i.e., employment feasibility (worker productivity, safety and interpersonal behaviour) and work tolerance (strengths, physical or mental stamina and coping with limiting factors such as pain)[1,8]. The Work Capacity Evaluation certifies that a person possesses those basic attributes necessary for employment in the open labour market[1].

Functional Capacity Evaluation is a systematic process of assessing an individualôs physical and/or mental capacity and functional abilities (work capacity). It is an evaluation of activities, used to make recommendations for participation in work, taking into account the personôs body functions and structures, environmental factors, personal factors and health status[4,9]. It establishes the physical and or mental level of work that an individual can perform.

The results of FCEs are used in a number of ways, i.e., to determine if an individual can return to work after suffering from an illness[1] such as major depressive disorder (MDD)[3,10-13],

compensation entitlement[1,14], to support claims or benefits application[1], to explore alternative career options[1,14] and as a basis for recommending modifications to the individualôs workstation or workplace[12]. The criticism of FCEs is their disregard for the environmental factors, which may present a significant barrier to returning to work[7].

Although these evaluations are performed by the occupational therapist as a member of a multidisciplinary team in mental health care practices to assess the employeeôs fitness for returning to work, some of the evaluations were initially developed for physical occupational therapy practices. Despite the constant changes in the workforce and workplace, in the clinical experience of the researcher, other team members have acknowledged the unique skills of occupational therapy practitioners in performing WCE hence the referring of employees to occupational therapy practitioners. Occupational therapists use a variety of standardised measurements[5,6,15,16] and non-standardised assessments[15-17] in clinical practice to assess the employeeôs ability to work. It is noted that FCEs are standardised and non-standardised batteries of tests, which all together form an evaluation of the capacity to perform work-related activities[9].

Occupational therapists with their knowledge of mental health[10,16,18,19], disability assessment[13] and activity participation[3,16,20] (specifically work related activity), are in a unique position to evaluate employees with disability and to establish the effect that their disabilities (physical and/or mental) may have on their functioning in the work place.

As stipulated by the Mental Health Care Act[21] (MHCA), 2002,

> ñA mental health care user (employee) who submits voluntarily to a health establishment for care, treatment and rehabilitation services, is entitled to appropriate care, treatment and rehabilitation services or to be referred to an appropriate health establishmentò where they will receive the appropriate level of mental health care (p. 24).

Occupational therapists are part of the mental health care practitioners who assist with assessment, intervention and rehabilitation of these mental health care users (employees). Since the intervention of occupational therapists also focuses on the employeesô functional independence with regard to areas of occupation (activities of daily living, leisure, social

participation and work)[20], they are also able to assess employeesô capacity to work[22] and to ascertain if they are employable or not.

Employees with MDD tend to experience challenges with their areas of occupation. Crepau, Cohn and Schell[3] point out the pervasiveness of major depressive disorder[3]. In the general population at any time, the prevalence of MDD is around 5%[11]. In the developing countries such as South Africa, the prevalence of MDD in the general population is likely to be high[23]. Worldwide, MDD is the fourth leading illness causing functional impairment, disability and days lost from work. Depression is the most prevalent mental disorder causing absenteeism from work, and the increasing number of disability pensions granted for MDD is a major concern[12]. Depression alone is believed to have the largest impact on prolonged work disability[24,25].

Employees suffering from MDD show an inability to perform even the simplest daily tasks. They are frequently pre-occupied with work, money, family and their own health problems. They show lack of energy and interest to perform their work (untidy appearance, lack of self-esteem, high sick absenteeism or poor work attendance, non-punctuality at work, poor work performance and poor work productivity); activities of daily living (poor appetite and neglect of self); leisure activities (spend more time sleeping and loss of interest) and social participation (social withdrawal and poor social skills)[3,10-13,24,26-29]. Given the occupational therapistsô role to help employees achieve functional independence, it follows that they have a major role to play in the assessment and treatment of employees suffering from MDD and that they form an integral part and contribution in the multidisciplinary team of mental health care practitioners.

Some studies indicate that by 2020, MDD is projected to be the second biggest cause of disease burden worldwide[10,27]. Major depressive disorder is the leading cause of disability and premature deaths through suicide attempts among people aged 18 to 44 years, and it is expected to be the second leading cause of disability for people of all ages by 2020[24,27]. Males over 50 years reported 128 days out of role and this has crucial implications for productivity in the workplace, considering that in a study of the effects of chronic medical conditions on work loss, the mean number of days out of role for most of the chronic medical conditions was less than 15[11]. Functional outcome in depression is worse than functioning in chronic medical disorders such as cardiovascular disease[24]. Despite its high prevalence, only

one-third of all patients with MDD receive adequate treatment[24]. This category of psychiatric illness is therefore of critical importance to mental health care practitioners and communities that need to collaborate to decrease the burden of disease.

Major depressive disorders are associated with reduced work productivity, as indicated by threefold increase in the number of sick days (absenteeism) in the month preceding the illness for employees with a depressive illness compared to co-workers who did not have such an illness[11,24]. Major depression can occur at any age from childhood to old age and it is more frequent in young adults than previously thought[11]. The mean age of onset is 25.8 years overall- 26 years for females and 25 years for males[13]. The median age of onset for South Africans is 26 years[30].

This median age clearly shows that major depressive disorder affects employees who have just joined the work force. It occurs twice as frequently in women than men and particularly in women with babies and young children. Similarly, women tend to have more sickness absence from work than men[31]. Twelve percent of depression cases evolve to a more chronic course[11]. The chronic form of depression accounts for 12-35% of major depressive disorder[24].

The benefit costs of long-term disability insurance claims for mental disorders have been a major concern in recent years in both the public and private sectors[33]. Depressive disorders are too often unrecognised and untreated and therefore become a cause of unnecessary and unmanageable distress and disability[24,34]. In the United States of America (USA), untreated depression costs close to 12 billion dollars in lost working days in the workplace each year[12].

Additionally, 11 billion dollars in other costs result from decreased productivity in the work place, mostly due to depressive symptoms that affect decision-making, attention span, fatigue, lack of energy, difficulty to concentrate and problems with memory[12]. This illustrates that worldwide the economy is seriously affected by depression. There is a lag of 3-5 years before the South Africans seek help[30] for the treatment of MDD. In a study by Seedat, Stein, Berk and Wilson[30] treatment drop out occurred in almost half of their respondents. This shows that the situation with regard to untreated depression and decreased productivity might be similar to the USA if not worse in the South African population as the researcher could not access the exact figures in costs. This illustrates that worldwide the economy is seriously affected by depression.

Mental disorders are said to account for at least 160 million lost years of healthy life in the world, of which at least 30% could have been easily averted with existing interventions and the disability weight of MDD could be reduced[32]. Mental disorders including depression have an impact on the employeeôs participation in employment. A greater percentage of lost healthy living and disability caused by MDD could be reduced by existing interventions[32]. Given the possible gain of these savings, investing in research to improve mental health services is certainly worthwhile[32]. Given the occupational therapistsô role to help employees achieve functional independence, it follows that they have a major role to play in the assessment and treatment of employees suffering from MDD and that they form an integral part and contribution in the multidisciplinary team of mental health care practitioners.

In Craikôs[19] review of literature on mental health, it was found that there had been few articles published on occupational therapy for people with enduring mental health problems. For example, only two articles on depression were found during that literature review. Similarly, there is a dearth of literature on occupational therapy mental health in South Africa, a country reported to have 9.8% of Major depressive episode in the clientôs lifetime and 4.9% for the past 12 months[13]. These figures are quite high and deserve more intervention or research than is currently visible.

In the Global burden of disease study, disability caused by MDD was found to be equivalent to that caused by blindness or paraplegia. With regard to years lived with disability, depressive disorders as a single diagnostic category were the leading cause of disability worldwide[32].

As expected, South Africa also faces problems associated with depressive disorders in employees. For instance, application for disability claims has been on the steady upward trend in recent years[35]. Among these claims, depression, anxiety, chronic fatigue and post-traumatic stress disorders appear at the top of DSM-IV diagnoses list[35]. Some people with disabilities benefit through disability grants[36]. The number of people receiving social grants has rocketed from 2.9 million in April 2000 to 7.9 million in April 2005[36]. It is anticipated that the number will increase by 20% per annum. According to the National Treasury since 2000/01, spending on disability grants increased from R4.0 billion (US $0.6 billion) to an estimated R10.3 billion (US $1.5 billion) in 2003/04. There is a concern that this growth is

not sustainable in the long term[36]. One way of curbing this exponential growth is to distinguish between those suffering from MDD and can possibly return to work, from those suffering from other mental health problems that are out rightly disabling. Those suffering from MDD might reduce applications for disability grants if properly assessed.

Psychiatrists in private practice are increasingly put under more pressure to declare a growing number of employees medically disabled. In particular, some employees have developed a strong ñoff work identityò as an integral part of the sick role, using this to justify their inability to return to work[29]. However, lack of standard procedures on how to deal with these cases has led to more referrals to occupational therapists. All disability related insurance claims on psychiatric grounds, should also be assessed and treated by a psychiatrist. In a study by Rytsala, Melartin, Leskella, Sokero, Lestela-Mielonen and Isometsa[12], they found the severity of depression to be the most significant factor associated with level of disability. The number of previous episodes of depression is associated with the degree of disability[27]. The preceding history of depressive illness, presence of co-morbid mental and physical disorder, female sex, and age were each significantly associated with at least some aspects of disability[12].

Function, impairment, and disability are words in which many physicians have little interest[37]. Most physicians are trained to deal with structure and physiology, but not function and disability[37]. Occupational therapists tend to focus and base their professional scope of practice on function and disability[1,3,20]. This could be because they are skilled in identifying the determinants of areas of occupation (activity of daily living, rest and sleep, education, work, play, leisure and social participation)[20]; client factors (body functions, body structures, values, beliefs and spirituality); performance skills (sensory perceptual skills, cognitive skills, emotional regulation skills, communication and social skills); performance patterns (habits, routines, roles and rituals); context and environment (culture, personal, physical, social, temporal, virtual) and activity demands (objects used and their properties, space demands, social demands, sequencing and timing, required actions, required body functions and required body structures)[20].

Ideally, a multidisciplinary team should be responsible for determining a personôs functional capacity. However, psychiatrists while assessing disability, express their professional opinions only on the degree of functional impairment and to indicate whether the employeeôs

condition is permanent or not, and rarely comment on disability[35]. As occupational therapists use the bio-psychosocial approach in assessment and intervention[7,10,16], they are in a better position to assess the employeeôs level of work capacity. Therefore, in the experience of the researcher, general practitioners (GPôs), psychiatrists, psychologists, insurance companies and employers refer their employees/clients/patients who suffer from ill health such as MDD to occupational therapists for FCE/WCE to assist in determining their employeeôs capacity to work.

In the experience of the researcher, occupational therapists practicing in South Africa have developed their own unpublished formats in their clinical practices that they use to evaluate employees suffering from MDD, as there is lack of research and publication in occupational therapy. This lack of effective documentation and standardised practices in dealing with employees with MDD is pernicious to the reputation of occupational therapy as a whole and suggest the desirability of concerted efforts towards generation of comprehensive knowledge in this crucial area of practice. This research is an attempt towards that end.

1.2 Background to the research problem

Functional Capacity Evaluation has evolved over the last 40-50 years with contributions from occupational therapy, vocational rehabilitation, physical therapy, psychology, kinesiology, physics, ergonomics and biomechanics[38]. Research is just beginning to examine the impact of psychosocial factors on FCE/WCE[4]. An analysis of the psychosocial factors is necessary in an FCE/WCE[39]. Occupational therapy practitioners focus on the individualôs ability to participate in productive occupations throughout the individualôs life span[14].

In private mental health care practices, there are many mental health care users (employees) who are hospitalised for major depression due to occupational problems (e.g. victimisation, harassment and bullying in the workplace) and they use depression as a means to apply for medical benefits (medical boarding/ incapacity benefits/ insurance compensation) so that they do not return to their occupation. Several reports have graphically illustrated the pain, mental distress, physical illness and career damage suffered by victims of bullying[40], who present with MDD and perceive themselves as unfit to work.

Major depressive disorder is not a straightforward mental illness to assess or to determine work capacity compared to other mental illnesses mentioned in the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV-TR) such as schizophrenia and dementia[10]. From the researcherôs clinical experience, some psychiatrists rely on the input of the occupational therapists when making final decisions with regard to the mental health care usersô (employeesô) work capacity and or fitness to work.

Medical practitioners are expected to comment on impairment while occupational therapists determine the clientôs disability by means of standardised and non-standardised work measurement tools. However, occupational therapists have different tools that they use to perform Work Capacity Evaluations. Not surprisingly, sometimes their recommendations during Work Capacity Evaluations are different for the same client/employee. The resultant different recommendations have caused serious concern for the researcher in the sense that it suggests not only lack of standardised measurements but also different conceptions of work capacity or practices when it comes to determining capacity for work regarding employees suffering from MDD. Bennette, Tooth, McKenna, Rodger, Strong, Ziviani, Mickan and Gibson[41] in their survey found that ñclinical experience, continuing education and colleagues are the most common sources underpinning clinical decision-makingò (p.22) by occupational therapists and only 42% base their clinical decisions on research evidence.

Occupational therapists tend to use both quantitative and qualitative approaches to assessment[15]. Consequently, some aspects of occupational therapy assessments are standardised, specific and meticulous, while other aspects are intuitive, fluid and creative[15]. Occupational therapists have to balance, reconcile and incorporate information from both approaches into the overall assessment process and resulting documentation[15]. The researcher is of the perception that it is possible to use different methods/tools of evaluation to perform work capacity with employees suffering from MDD in occupational therapy practices. However, the practice of functional assessment of work capacity by occupational therapists has gone unnoticed and undocumented in the wider sphere of rehabilitation[42].

A survey of Occupational Therapy Practitioners in Mental Health, states that there is a need to develop and use standardised measurements and clinical outcome measures[18]. These points to a need for further research in understanding why occupational therapistsô outcomes in determining work capacity differ especially with respect to employees suffering from MDD.

Therefore, the need for objectivity in the assessment process is a challenge continually being addressed by researchers, academics and clinicians[14].

1.3 Research problem

It is clear that occupational therapists have the skill to give their professional opinion on the employeeôs disability, while the other mental health care practitioners who are part of the multi-disciplinary team base their findings and medical report on impairment. Depression causes as much or more disability (e.g. missed work, days in bed) than chronic medical conditions.

Consequently, psychiatrists are frequently asked by employees, employers, or insurers to complete disability evaluations for employees with MDD[35]. Some psychiatrists reflexively declare employees with depression as incapacitated to work, and support their disability claims regardless of whether the employees meet the disability criteria (which vary by occupation and insurance policy) or not. While such psychiatrists feel that they are acting out of loyalty to their patients, unsubstantiated support for disability promotes invalidism and chronicity of illness[35]. The employer, insurer and employee each have their own interests; psychiatrists cannot serve all three simultaneously and equally. Therefore, the researcher is of the opinion that the decision should be based on the effect of the change on functioning and that this process should be objective and scientific regarding the assessment of employees, as there will be an increase in disability claims especially because of employees who suffer from MDD.

As long as the employee has received adequate treatment, major depressive disorder should only rarely cause permanent disability. Given that occupational therapists can assess and intervene, they should be seen as crucial in the treatment of MDD as well as efforts to increase return to work rates.

Major depressive disorder is a relevant condition to consider in this regard because of its high prevalence, strong impact on short-term work disability, and low rate of treatment[43]. The challenge that faces occupational therapists is that there is no specific guideline and process. The recommendation is that the occupational therapy profession in mental health should

move toward the use of standardised assessment to ensure quality in their practice[44]. A survey of occupational therapy practitioners in mental health also indicated a need to develop, use standardised assessment and outcome measures as important issues reinforcing their identified need for more occupational therapy specific training in this area of mental health[18]. This will reduce conceptual confusion about how to assess functional capacity for return-to-work[42]. Gibson and Strong[42] cite Velozo who has raised concerns about the confusion that exist about definitions and terms used in functional assessment for work.

The researcher has also noted that conflicting opinions are given with regard to the outcome of WCEs and recommendations in OT reports. There is varied use of standardised measurements and sometimes an absence of these in some occupational therapy practices. The researcher has noted that occupational therapists do not deliver similar services as the majority of them do not use standardised measurements in their practices and hence a need for further training in this area. Additionally, more research is needed to explore how psychosocial factors influence the validity and outcome of FCE testing[4]. A survey of 136 occupational therapy practitioners in mental health regarding assessment, practice and frame of references in mental health concluded that there was no consensus about scope of practice, assessment or service delivery[45]. Indeed occupational therapy assessments in general need to be clear about what they do and do not measure, so that they can employ appropriate measures or tools for a specific purpose of a particular assessment[42]. The problem therefore is that the perceptions and practices of occupational therapists in determining work capacity of employees suffering from MDD are too varied.

1.4 Research question

Following from the last point made above, the research question is: What are the perceptions and practices of occupational therapists in determining work capacity of employees suffering from major depressive disorder?

1.5 Aim of the study

The aim of this study was to describe the perceptions and practices of occupational therapists in determining work capacity of employees suffering from major depressive disorder.

1.6 Objectives of the study

The following objectives were identified:

i. To determine the perceptions of occupational therapists when dealing with employees affected by MDD during WCE.

ii. To identify current OT practices implemented during WCE of employees with MDD.

iii. To develop a possible process of WCE with employees suffering from MDD.

iv. To formulate the general occupational performances that the occupational therapist should assess to determine the WCE of employees with MDD.

1.7 Definition and clarification of key concepts and terms

In this study, the following definitions and concepts are applied:

Work capacity

Work capacity is the ability to sustain performance in response to broadly defined work demands[1].

Work Capacity Evaluation

Work Capacity Evaluation (WCE) is defined as a comprehensive process that systematically uses work, real or simulated, to assess and measure an individualôs physical abilities to work[1]. Work capacity evaluation is a systematic method of measuring a workerôs ability to perform occupationally meaningful tasks safely and dependably, for evaluating their fitness and risks when starting to work or when returning to work after an injury or illness[5]. Work capacity evaluation is also used to determine the presence of

disability[5]. Work incapacity is the inability to perform gainful work related activities because of a physical, emotional or mental impairment[46].

Functional Capacity Evaluation

Functional Capacity Evaluation (FCE) is defined as a systematic, comprehensive and objective measurement of a personôs maximum work ability[4]. The terms FCE and WCE tend to be used interchangeably in literature and various studies and this study will follow suit.

Standardised test/measure/assessment/instrument

The above is defined as a published measurement tool, designed for a specific purpose in a given population, with detailed instructions provided as to when and how it is to be administered and scored, interpretation of the scores, and results of investigations or reliability and validity[15]. A standardised assessment has a set procedure that the therapist must precisely follow when administering it. Thus, standardised assessment helps to ensure minimal variation in the way tests are carried out at different times and by different testers[15]. It therefore, implies uniformity of procedure in administering and scoring[15].

Non-Standardised Assessment

Non-standardised assessment provides an occupational therapist with information but have no precise comparison to norm or a criterion, and their psychometric properties have not been researched and documented[15].

Impairment

Impairment is the alteration of normal functional capacity due to a disease. It is assessed by medical means, after a diagnosis has been established and appropriate optimal treatment applied[35]. Impairment is also defined as the loss and/or abnormality of mental, emotional, psychological or anatomical structure or function. This term includes all losses or abnormalities, not just those attributable to the initial patho-physiology, and includes

pain as a limiting experience[1]. Impairments may be temporary or permanent, and includes the existence or occurrence of an abnormality, defect or loss in a limb, organ, tissue or other structures of the body, including the systems of mental function. It reflects disturbance at the level of the organ[14].

Disability

Disability is the alteration of capability to meet the personal, social or occupational demands due to impairment and is assessed by non-medical means[35]. It is regarded as, a severe medically determinable impairment that has lasted or is expected to last for 12 months[46]. Disability encompasses vocational, educational, psychosocial, and financial factors[21]. The term represents objectification of impairment, and reflects disturbances at the level of the person. Disability is concerned with abilities, in the form of activities and behaviours that are generally accepted as essential components of everyday life, such as excretory control or the ability to walk[14]. Therefore, disability is the summation of the role consequences of functional limitations[6].

Disabled person

Disabled person is a person who has a long-term or recurring physical or mental impairment, which substantially limits their prospects of entry into, or advancement in, employment[36,47] and has substantial and long-term adverse effects on a personôs ability to carry out normal daily activities[48].

Work disability

Work disability is defined as an inability to perform job tasks as a consequence of physical or mental unfitness[49].

Mental health care practitioner

Mental health care practitioner refers to a psychiatrist, registered medical practitioner, nurse, occupational therapist, psychologist or social worker who has been trained to provide prescribed mental-health care, treatment and rehabilitation services[21].

Employee

An employee is a person who is hired to work for another or for a business, firm in return for payment[50]. For the purpose of this study, employees will also be referred to as patients and or clients.

Mental health care user

A mental health care user means a person receiving care, treatment and rehabilitation services or using a health service at a health establishment aimed at enhancing the mental health status of a user, state patient and mentally ill prisoner[21].

Major depressive disorder (MDD)

Based on the five non-somatic DSM-IV-TR classifications, the criteria for major depressive disorder include depressed mood, diminished interest or pleasure, feelings of worthlessness or inappropriate guilt, diminished ability to think or concentrate or indecisiveness and recurrent suicidal ideation[28,51,52]. A psychiatrist must have made the diagnosis.

Perception

Perception is the insight, intuition and or knowledge gained by perceiving or interpretation or the capacity to have such insight[50]. In this study, perceptions of occupational therapists refer to the occupational therapistsô capacity to have insight and knowledge gained in performing work capacity evaluation.

Practices of occupational therapists

To practise as an occupational therapist, one must have completed a degree in occupational therapy at a recognised and accredited university, be registered with the appropriate professional body and use the developed standards of practice and the minimum acceptable standards of occupational therapy services[53]. Occupational

therapists who practice in South Africa must register with the Health Professions Council of South Africa. When the occupational therapist puts into practice what s/he actually does, it is further influenced by the environment of the practice, which includes the society and culture in which practice takes place, the needs of a particular client group (employees with MDD in this study), the location (i.e. in a hospital or in the community), and a host of other contextual factors, including the personal experience of the therapist[54]. The therapist employs the unique combination of personal experience, knowledge, skills and values, which combine to form the practice of occupational therapy[54]. Assessment of levels of performance in occupational therapy areas, and of occupational roles and skills comprises a large part of occupational therapy practice[54]. These core processes, guided by clinical reasoning and practical experience, form the unique art of practice of occupational therapy[17]. In this study, practices of occupational therapy refer to the way in which occupational therapists conduct their WCE and interventions for employees suffering from MDD.

Reasonable accommodation

Any modification or adjustment to a job or to the working environment that will enable a disabled person to participate in employment[47]. Alternatively, any modification in the work environment or in the way work is customarily performed that enables an individual with a disability to enjoy equal employment opportunity [1].

Areas of Occupation

The ability to carry out activities of daily life includes activities in the areas of occupation: Activities of Daily Living[20,55] (Basic Activities of Daily Living and Personal Activities of Daily Living), Instrumental Activities of Daily Living, education, work, play, leisure, and social participation. Occupational performance is the accomplishment of the selected activity or occupation resulting from the dynamic transaction among the client, the context, and the activity. Improving or enabling skills and patterns in occupational performance leads to engagement in occupations or activities[56]. It includes performance skills such as sensori-motor, cognitive, psychosocial, and psychological skills. Abilities are the elements of functional performance in which occupational

therapists have expertise to assess and intervene for improved performance[1,3,20]. The areas of occupation are life tasks such as activities of daily living, work, and play or leisure[1,3,20].

1.8 Scope and demarcation of the study

This study was limited to the perceptions and practices of occupational therapists in determining work capacity evaluations pertaining to employees applying for disability related benefits within the South African context.

It was limited to employees who suffer from MDD. It must be noted that major depressive disorder commonly tends to be misused by employees[24] and mental health care practitioners to apply for disability benefits since the effects of the disorder on work capacity are not as easy to evaluate as those of other mental illnesses such as schizophrenia and dementia[10].

It was further limited to occupational therapists who practice in the field of vocational rehabilitation and mental health, specifically their assessment procedures during work capacity evaluation in general and on employees suffering from MDD in particular.

1.9 Ethical considerations

The following ethical principles were considered during this study:

1.9.1 Principle of beneficence

- **The right to freedom from harm and discomfort**.

The principle of beneficence imposed the duty of the researcher to minimise harm and to maximise the benefits[57].

Following this principle, during phase one, two and three, the researcher ensured that the questions asked of the participants would not harm them by ensuring that the questions were not sensitive to avoid upsetting the participants[58]. There was more benefits[59-61]to the

participants than risks[57]. The participants benefited by taking part in phases two (self-rated questionnaire) and three (focus group interviews) since it enabled them to evaluate their level of competency, thus affording them an opportunity to reflect on their execution of work assessments. Since this study aims to benefit occupational therapy as a profession, it is hoped that the participants will also benefit from the published findings.

Some of the participants experienced ñpsychological distressò[35], when challenged by others during the focus group interviews. Other participants felt incompetent or insecure about their knowledge and skills (ways of performing work capacity evaluation) during the focus group interviews with the researcher. It must be noted, ñprotecting human beings from physical harm is often straightforward, but it is not as easy to address the psychological consequences of participating in a study, which can be subtleò[57](p.121). As such a debriefing session was conducted[57,62] at the end of the session by the researcher in a support group, since there is greater need for sensitivity in qualitative studies[57]. The participants were supported and encouraged during the focus group interviews. Some of the participants indicated that they had benefited considerably from the stimulating dialogue in the focus groups. Therefore, the principle of beneficence was implemented.

There were minimal costs[63] involved for participating in the research study because the researcher had organised neutral venues for participants in both Johannesburg and Pretoria. The researcher provided food for the participants and tokens of appreciation at the end of the focus groups.

- **The right to protection from exploitation**.

The participants were assured that their participation, or the information they provided, would not be used against them in any way[57]. This principle was implemented since the participants cannot be identified in any way during a study.

1.9.2 Principle of respect to human dignity

- **The right to full disclosure**.

Respect involves caring for others, honouring them and treating them with dignity[63]. The researcher ensured confidentiality with the participants even though he was familiar with all of them as colleagues during the focus group interviews. During phase one of the study questions, the participants were not expected to identify themselves in any form so as to provide anonymous responses. The researcher allowed each participant to complete the written consent form prior to his or her involvement in the study during each of the three phases. The researcher ensured that each participant received and completed a letter of ñinformed consentò[59-61,63-66]. They were given all relevant information about the study and informed that they could withdraw at any time prior to or during their participation. The researcher securely kept all the copies of the Informed Consent Form.

All the participants consented voluntarily and the researcher obtained permission from relevant authorities with regard to participants employed in organisations.

The research proposal was submitted for review and critique to the University of Pretoria (UP) lecturers who gave guidance and support. It was later submitted to the UP Faculty of Health Sciences Research Ethics Committee (certificate number S34/2007) and the University of Pretoria Research Committee for approval. This further ensured that the principle of respect for human dignity was upheld[66]. A competent occupational therapist lecturer supervised the researcher throughout the research process.

1.9.3 Principle of justice

- **The right to privacy**.

In phase one and three, the researcher implemented a fair selection of participants[59], by posting the questionnaires to occupational therapists who practice in the field of mental health and vocational rehabilitation some of whom are members of the Occupational Therapy Association of South Africa (OTASA). The participants were reassured about their rights to

privacy and sensitivity[61,62,64,65], and that those rights were protected[57,66]. The participants were reassured that the information or data collected would only be used for research purposes and would be treated confidentially. It was made known to them that if there was any information the researcher found necessary to record verbatim on paper, the researcher would seek consent from the concerned participant. The participants were assured that their participation would not be divulged or identified in any form[58,66]. As such, the participants could not be identified from the patterns of answers given in the data[58].

The researcher respected the contract made with participants concerning time, confidentiality and data collection. Audio recordings were only used for purposes of the study.

During phase one (descriptive questions) and phase two (questionnaire), the participants were free not to answer all the questions. Much to the benefit of the study, they answered all the questions. The results were represented with honesty and trust, to avoid any manipulation.

- **The right to fair treatment**.

The researcher treated participants who declined to participate in the study in a non-prejudicial manner[57]. The researcher related well with them and promised to invite them to share the study results if they wished to do so.

1.10 Significance and contribution of this study

This is a new line of enquiry in the occupational therapy profession, and studies of this type of enquiry could not be found in the literature review.

This study will assist occupational therapists to have a uniform understanding and approach while performing WCE in their day-to-day clinical practices when dealing with employees suffering from MDD. It will promote problem-solving and clinical reasoning in the profession of occupational therapy by exploring the variant approaches to perception on WCE in general. The researcher hopes that it is possible to influence occupational therapy practices towards a standard procedure/process, thus enhancing the future integrity of occupational therapy as a profession. Other mental health care practitioners, it is also hoped,

will develop more trust and reliability in the occupational therapist owing to the possible standardisation of WCE results on the same employee derived from similar conceptions and procedures. Such a situation will reflect improved validity and reliability.

By extension, this desirable situation will assist in the reduction of unnecessarily protracted approval of insured disability benefits caused by MDD, since it will equip occupational therapists with a clearer and standardised understanding with regard to WCE of employees suffering from MDD.

Occupational therapists must not ignore the saving of additional depression-related costs to employers of paying long-term work disability benefits and of hiring and training replacement workers. In addition, cost estimates exclude non-salary costs of having depressed employees, who might be involved in an increased number of accidents[43]. At the same time there can be, lost profits because of poor worker performance and reduced productivity of co-workers who might be adversely affected by interacting with depressed workers[43]. This statement shows that if occupational therapists have a specific guideline, most companies will save money because their depressed employees will be appropriately placed in the job that they can perform, or they will be able to return to work earlier. For those employees who present with work related grievances, it will give them an opportunity to resolve them rather than applying for incapacity benefits.

It is clear that employment of people with mental illness is minimal and in fact, national departments attained only 0.47% against a target of 2% employment rate of disabled people in the public sector[36]. That being the case, it is prudent to retain or rehabilitate employees with MDD rather than have them out of work, which will expose them to hiring prejudices. This study is an effort towards that end.

It is planned that the findings of this research will be presented at occupational therapy congresses locally and internationally, psychiatric occupational therapy support groups (POTS) as well as any other relevant platforms in the field of psychiatry.

A scientific article related to the findings of this research study, will be published in the *South African Journal of Occupational Therapy*. Such an effort will hopefully, create dialogue with

extant knowledge, add new insights and provoke discussion. The researcher will follow the guidelines for publishing as outlined in the *South African Journal of Occupational Therapy*.

1.11 Layout and organisation of this study

This study contains the following chapters and annexures:

Chapter 1: This chapter presents an introduction, background to the research problem, aim and objectives of the study, ethical considerations, significance and contribution of the study

Chapter 2: This chapter discusses the literature review of the following topics related to this study: Major depressive disorder, the effect of MDD in the workplace, South African legislation, Work Capacity Evaluation, Occupational Performances and the return-to-work decisions.

Chapter 3: This chapter describes the research designs, methods and strategies. It gives a clear picture of the selection of participants, data collection methods, data analysis and measures to ensure trustworthiness of the study.

Chapter 4: This chapter presents the research findings coded into themes. The results are discussed in conjunction with relevant literature.

Chapter 5: This chapter concludes the study following the themes that emerged from it. The chapter also discusses recommendations, non-consensus items, evaluation of the study, recommendations for future research, and offers the researcherôs personal reflection

1.12 Conclusion

Work Capacity Evaluation with employees suffering from major depressive disorder is an important area for occupational therapy since most of the employees treated in private practices suffer from MDD because of work related issues and poor work performance.

Occupational therapists have an important role to play in the assessment of employees suffering from MDD.

1.13 Summary

In this chapter, a brief motivation for this study was discussed, including the aim and objectives of the study. The contribution of the study was cited in terms of publication, presentations (seminars, conferences), and reducing costs for companies with employees suffering from MDD and incapacity management. The layout of this study concludes this chapter. Chapter 2 is a literature review on major depressive disorder, the scope of occupational therapy in mental health and work capacity evaluation.

CHAPTER 2

LITERATURE REVIEW

2.1 Introduction

Dealing with perceptions and practices of occupational therapists during work capacity evaluation of employees suffering from major depressive disorder, a rare and complex concept in occupational therapy literature, requires that this chapter focus fully on relevant topics that encompass this subject.

Relevant topics include the concept of major depressive disorder and its implications, the South African legislation that protects the rights of employees with disabilities, the role and function of occupational therapists as members of the mental healthcare team, work capacity evaluation of employees with MDD, occupational performance and return-to-work decisions.

2.2 Major depressive disorder

2.2.1 Global burden of disease studies

Global burden of disease studies have estimated that psychiatric disorders are major contributors to the disease burden worldwide[34]. The four mental disorders that pose the greatest burden in adults and children are depression, schizophrenia, alcohol use disorders and developmental disabilities (mental retardation, attention deficits hyperactivity disorder and autism)[67]. It has been recognised that mental illness is a major cause of disability[68]. The Global burden of disease project estimates that psychiatric conditions are associated with about one-quarter of the disability in the world[68]. ñThe most striking increases in the burden of neuropsychiatric disorders were projected for Asia and Ireland, the Middle Eastern crescent, sub-Saharan Africa, and Indiaò[69](p.1502). In countries such as South Africa, additional factors such as poverty and gender inequality are the key risk factors for psychiatric disorders[34]. Although South Africa has undergone a dramatic economic and political transition in the past decade, many of the distortions and dynamics introduced by

apartheid continue to reproduce poverty and perpetuate inequality[36]. Approximately one third of all South African households are living in poverty[36]. The rapid social and economic changes occurring in the nation at present may undermine family care systems that facilitate improved outcomes in psychiatric disorders[34]. Most mental disorders appear to be the result of a complex interaction of an array of interacting biological vulnerabilities and dispositions, environmental and psychosocial events[67].

2.2.2 Prevalence of MDD

Depression is one of the most prevalent psychiatric disorders and it has been recognised as a disorder from early Egyptian times[70]. In fact, adolescentsô prevalence rates for depression closely approximate those of adults, indicating that, in many cases, adult depression may have its onset in adolescence[71]. Depression was ranked as the seventh most important cause of disease burden in low-income and middle-income countries[67]. In the Global Burden of Disease (GBD) Project, depression was ranked the fourth in terms of global burden. It was predicted to rank second by 2020[72]. According to several studies, major depressive disorder is the leading cause of disability amongst adults in the world[24,73]. Depression is the leading cause of disease burden in Brazil, and the second leading cause in women in Chile[67].

2.2.3 Signs and symptoms of MDD

Individuals acquire a vulnerability to depression following uncontrollable or negative life events[26]. Research indicates that environmental factors do not cause severe depressive episodes[70]. As Christiansen and Baum[74] point out that the brain stem, limbic system and hypothalamic connections with nor-adrenaline and serotonin neurotransmitters are suspects with depression.

Depression is probably the most common of psychiatric symptoms. Major depressive disorders are diagnosed according to the presence of core depressive symptoms, associated symptoms, and the nature, quality and duration of symptoms[33]. Depression may present in diverse ways: it may vary across age, gender, culture and medical settings. At the core, depressive disorders have two main elements: low mood and anhedonia, or a lack of capacity to experience pleasure in life[34,70].

Table 2.1, adapted from Baumann[34] indicates the symptoms of depression as follows:

Table 2.1: Symptoms of depression

Emotional changes	Biological changes	Cognitive changes	Behavioural changes
• Low mood • Anhedonia • Irritability • Hopelessness • Loss of self-esteem and feelings of worthlessness • Guilt	• Disturbed sleep pattern • Loss of appetite • Loss of libido • Loss of energy • Pain	• Impaired attention and concentration	• Psychomotor slowing and agitation • Social withdrawal

Symptoms of depression have been accurately recognized and properly diagnosed as MDD. These terms allow the psychiatrist and the employee to conceptualise the course of depression longitudinally. A response is a point in time where symptoms have decreased to the point where the criterion for MDD is no longer met. A remission refers to a period in time and it can be either partial or full. A partial remission is the period during which an improvement of sufficient magnitude exists that the criteria for MDD are no longer met. A full remission is the period after partial remission when the patient becomes asymptomatic. A relapse is the return of symptoms after full remissions that satisfy full diagnostic criteria before recovery has occurred. A recovery is a prolonged full remission for at least six months during which the patient is asymptomatic. A recurrence is the appearance of a new episode of depression with symptoms that meet full criteria and thus can only occur after recovery. These terms serve to remind the researcher that depression is often a chronic disease, with many patients suffering multiple episodes and some never achieve complete recovery. Hence Gold and Shuman[24] observe that major depressive disorder is episodic, with circumscribed, acute major depressive episodes reoccurring throughout the personsô lifetime. This shows that once a person receives treatment for major depression, there are high chances of relapses. For example, if an individual has had a major depressive disorder, there is a 50% chance of having a second. After having two major depressive disorders, there is a 75% chance of having a third, and after three depressive episodes, there is 90% chance of future major depressive disorders[24].

The heterogeneity of symptoms seen in depressed patients also stems from the high rate of psychiatric, medical and psychosocial co-morbidity seen in these patients[26]. In the diagnosis of the depressive disorder, psychiatrists often use the mnemonic ñSIGECAPSò (sleep, interest, guilt, energy, concentration, appetite, psychomotor, suicide) as a useful clinical guide (i.e. four or more SIGECAPS for major depression, two or three SIGECAPS for dysthymia)[27]. According to DSM-IV-TR, for a diagnosis of major depressive disorder, symptoms must last at least two weeks, and typically, a person will experience at least four symptoms that include changes in appetite and weight, changes in sleep and activity, lack of energy, feeling of guilt, problems thinking and making decisions, and recurring thoughts of death or suicide[28,52].

The exact mechanisms of how depression impacts function are not entirely clear. It has been proposed that depression may impair cognitive functioning, which in turn decreases sustained concentration[4,24]. Anhedonia and similar depressive symptoms may act to decrease motivation to sustain effort on tasks, while negative thoughts and beliefs that accompany depression may increase negative thoughts about pain[4]. Combined, these symptoms may decrease beliefs that one can successfully perform certain tasks[4]. Witchen and Pittrow[72] offer a comprehensive list of these symptoms based on one of their studies:

> ñThe most commonly reported symptoms were loss of energy or fatigue (79%), insomnia/sleep problems (77%), depressed mood (59%), and loss of concentration (47%), followed by loss of libido (45%), and loss of interest/anhedonia (40%). The proportion of patients reporting suicidal ideation or acts in the previous two weeks was notably high (20%). This overall symptom profile, and in particular the relative rarity of the loss of weight/appetite (28%), psychomotor retardation (34%), and reduction of self-confidence/ self-esteem (36%), is different from that observed in mental health speciality settingsò (p. S5).

Most of the symptoms mentioned by Witchen and Pittrow[72] are similar to those mentioned in Table 2.1, and a clear picture of their occurrence is highlighted in their study, which shows that energy levels, sleeping patterns, depressed mood, loss of concentration and loss of interest/anhedonia are the key areas to assess.

Persons and Fresco[26] predict that the autonomous depressed patient experiences certain specific symptoms, including unremitting anhedonia that is independent of good and bad events, inhibited crying, avoidance of others to maintain autonomy, and rejection of help from others.

The DSM-IV-TR provides diagnostic criterion sets to help guide the clinician in making the correct diagnosis and how to differentiate a disorder from other disorders that have similar presenting characteristics[75]. The DSM-IV-TR is a categorical classification that divides mental disorders into types based on criterion sets with defining features[75]. The DSM-IV-TR lists the criteria for major depressive disorder as follows[28]:

A. ñFive (or more) of the following symptoms have been present during the same two-week period and represent a change from a previous functioning; at least one of the symptoms is either (1) depressed mood or (2) loss of interest or pleasure.
   (1) Depressed mood most of the day, nearly every day, as indicated by either subjective report (e.g., feels sad or empty) or observation made by others (e.g., appeared tearful).
   (2) Markedly diminished interest or pleasure in all, or almost all, activities of the day, nearly every day (as indicated by either subjective account or observation made by others).
   (3) Significant weight loss when not dieting or weight gain (e.g. a change of more than 5% of body weight in a month), or decrease or increase in appetite nearly every day.
   (4) Insomnia or hypersomnia nearly every day.
   (5) Psychomotor agitation or retardation nearly every day (observable by others, not merely subjective feeling of restlessness or being slowed down).
   (6) Fatigue or loss of energy nearly every day.
   (7) Feeling of worthlessness or excessive or inappropriate guilt (which may be delusional) nearly every day (not merely self-reproach or guilt about being sick).
   (8) Diminished ability to think or concentrate, or indecisiveness, nearly every day (either by subjective account or as observed by others).

(9) Recurrent thoughts of death (not just fear of dying), recurrent suicidal ideation without a specific plan, or a suicide attempt or a specific plan for committing suicide.

B. The symptoms do not meet criteria for a mixed episode.

C. The symptoms cause clinically significant distress or impairment in social, occupational or other important areas of functioning.

D. The symptoms are not due to the direct physiological effects of a substance (e.g. a drug abuse, a medication) or a general medical condition (e.g. hypothyroidism)ò (p.534).

There are agreements with regard to the symptoms of major depressive disorder while using different literatures and most of them fit the DSM-IV-TR as stated above.

There are instruments that measure the overall symptom profile of depression as well as its cognitive, behavioural, and mood components, life events and the underlying cognitive diathesis[26]. It is also useful to assess a depressed patientôs strength and resources[27].

The DSM-IV-TR aids in providing a psychiatric diagnosis. However, arriving at such a diagnosis does not guide treatment nor predict outcomes[76]. People differ in many ways, which can affect treatment and outcomes[76]. Psychiatric diagnosis does not prescribe important occupational therapy purposeful activities to the individual nor what the individual needs to accomplish in order to survive[76].

2.2.4 The multidisciplinary treatment of MDD

Generally, the treatment of depression has three phases: acute, chronic and maintenance. Depressed individuals have poorer treatment adherence, thereby reducing the benefits of medical treatments[73]. Different trials have shown that antidepressants were more effective in combination with psychotherapy than alone[67]. There is no evidence on the effect of medication and psychotherapy on return-to-work from long sick absenteeism of depressed workers[77].

Psycho-education involving patientôs social support system or caregiver may reduce disability via improved medication compliance or improved quality of social support. Individuals with decreased social support may benefit from case management and specific psychotherapeutic regimens such as interpersonal or cognitive behavioural therapy[73].

Because functional disability is a risk factor for depression, the possibility of preventing or treating depression in rehabilitation settings should be explored[73]. This indicates the need for more clinical evidence, research and clarifications from occupational therapists regarding their intervention and rehabilitation programmes involving employees suffering from MDD.

These leads to a more general explanation on the role of occupational therapist in mental health care practices.

2.2.5 The role and function of the occupational therapist as a member of the mental health care team

2.2.5.1 The philosophy of occupational therapy

Occupational science which is the study of the human as an occupational being, addresses the issue of enabling people with disability to be reconnected to elemental routines and thus to their proper place in their culture[78,79]. Occupational science promises to address some of the major dilemmas of occupational therapy practice and the place of the occupational therapy profession in society[79]. Occupational science assists the occupational therapist to analyse the relevance of the intervention that is provided to clients who suffer from major depressive disorder.

Occupational therapy practitioners enable their clients to seize, take possession of, or occupy the space, time, and roles of their lives at home, school, the workplace and places where they engage in recreation or leisure[78]. Occupational science successfully meets environmental demands and influences the state of the clientôs own health using hands, mind and will[79]. Occupational therapy is based on the belief that purposeful activity (occupation) prevents or mediates dysfunction of physical or psychological origin[1]. The simplest and best way to explain occupational therapy is that it enables individuals of all age groups to cope with their

roles and tasks at home, in social settings and at work despite the presence of some residual symptoms of illness. The essence of occupational therapy is built on a belief in the necessity and value of occupation[7].

Occupation in this sense denotes personal care, household, leisure and work activities[1]. Of all the occupations in which people engage in across their lifespan, work arguably occupies the most central position[7]. Therefore, if mental illness or any mental health problem interferes with the normal way of how people occupy their time, engage themselves in work, occupational therapy is then indicated. Dysfunction is the problem that is causing, or may cause, the personôs difficulty in occupational performance and that brings the client to seek or be referred to occupational therapy[80].

The relevance of occupational therapy is supported by findings that problems in daily functioning of a person are the reason for a decrease in quality of life[55]. Occupational therapists pride themselves on being lifestyle specialists[81]. They work with clients to attain maximum lifestyle benefits[81]. Occupational therapy may only be valued as an adjunct to the use of psychotropic medications or as counsellors who conduct talk groups[79]. The goal of occupational therapy is to develop a sense of self-esteem and competency within an individual[76]. This task may be more challenging in dealing with clients with MDD.

Lloyd, King and Bassett[81] found that occupational therapistsô working in mental health spend between 25% and 74% of their time on occupational therapy specific tasks as opposed to generic tasks. Occupational therapists are divided into two groups[81]. One group which tends to be younger and less experienced, is engaged in more traditional specialist rehabilitation activities, such as assessments, activities of daily living, group work and community orientation and access. Much of the work undertaken by the second group requires skills that do not form part of core education and training in undergraduate programs, for example mental state examination, and medication education[81]. Occupational therapy evaluations will be discussed later in this chapter.

2.2.5.2 Occupational therapy intervention

The use of activity as therapy in institutions for the mentally ill lay dormant for decades[1]. The uniqueness of occupational therapy lies in the use of occupation as a curative or restorative force as well as the view that enhanced occupational performance is the desired goal of therapy[78]. Occupational therapists have assumed a variety of roles: for example anxiety management, counselling, case management, work programmes, and rehabilitation[82]. Intervention aims to assist an individual to fulfil social roles and participate fully in life[83]. When therapy targets the clientôs quality of life or health related quality of life, community integration or reintegration and social roles, then therapy is targeting participation[83]. Quality of life may be reflected in the purposeful participation as a member of the community, emotional well-being, sleep or rest, energy or vitality and life satisfaction[76]. In the presence of or threat of a disabling condition, people often need to develop new skills to manage their environment and use their time in satisfying ways[79].

An occupational therapist needs to show some competency and self-efficacy[84] at individual and organisational levels[85] and in the process upholding professional excellence and accountable leadership[85]. Competency is the ability of a professional to use knowledge, skills, attitudes, and judgement associated with a profession to practice with skill, efficiency and safety in order to provide high quality care that improves clientsô outcome[86].

Self-efficacy refers to personal judgements of oneôs capacity to organise and implement actions in novel or unpredictable situations[74,84]. High levels of experience are related to high levels of skill and reasoning, which, arguably, may lead to professional excellence[85]. It is suggested that to achieve professional excellence, experience in practice must be combined with a practitionerôs ability to effectively self-critique[85]. Understanding oneôs limitations in knowledge and expertise is an essential component of professional excellence[85]. Leadership component commonly involves being a role model or resource as well as doing ground breaking work, which involves trust and integrity[85]. Additional skills needed include respect for others, responsibility, problem solving, flexibility, confidence, cooperation, constructive handling of frustration, modification of behaviour in response to feedback, giving constructive feedback and balancing obligations[87]. These qualities define how clinicians are expected to assess, treat and interact with clients as they provide care[86], since it has been

estimated that current clinicians are particularly unlikely to possess skills regarding client self-advocacy, rehabilitation, functional assessment[86] and case management[84]. Major depressive disorder also poses a challenge to the occupational therapist as it affects the employeeôs work performance.

2.3 The effect of MDD in the workplace

Major depressive disorder depresses function and mood[3]. To the depressed person everything seems difficult to do, or such an individual may feel life is not worth the effort[3]. Depending on the degree of severity, depression can affect all occupational performances[3]. There is impaired concentration, impaired ability to function in work and in a range of other roles, and impaired personal relationships[11]. Almost all depressed patients (97%) complain about reduced energy, they have difficulty finishing tasks, are impaired at school and work, and have less motivation to undertake new projects[28].

Depressive disorders are too often unrecognised and untreated and therefore become a cause of unnecessary and unmanageable distress and disability[34]. Individuals treated for depression are significantly more likely to be working after twelve months than untreated individuals[24]. Persons with sub-threshold levels of depression exhibit high rates of health care use and require substantial medical care cost[75]. Depression causes absenteeism from work and, even more importantly presenteeism, that is, loss of productivity while the employee is present at work but is impaired as a result of mental health symptoms[24,77]. The study by Gold and Shuman[24] has demonstrated the association between depression and absenteeism. Depression related presenteeism due to symptom impairment presented a bigger problem than absenteeism[24]. In the United States of America (USA), untreated depression costs close to 12 billion dollars in lost working days in the workplace each year[12]. As an employee goes off sick, the cost benefits are not seen as so immediate, especially as many do not recognise the hidden cost of sickness absence such as providing temporary or long-term replacement, overtime paid to other employees to cover the additional workload, and the adverse effects on staff morale[88]. Additionally, 11 billion dollars in other costs result from decreased productivity in the work place, mostly due to depressive symptoms that affect decision-making, attention span, fatigue, lack of energy, difficulty to concentrate and problems with memory[12,24]. Presenteeism may provoke problems at work caused by cognitive limitations,

emotional restrictions (guilt, loss of interest and initiative) and social restrictions (introverted behaviour, social anxiety)[24,77]. Relapse and recurrence following successful treatment of major depressive disorder is common and often carries massive social cost[89].

Depression tends to be disabling, recurrent or chronic and untreated[67] in low income and middle-income countries. There is a concern that a state of reactive depression will become a chronic response and that the employees self-concept may continue to be that of a disabled, dependent, and helpless person[1]. In a study by Lenze, Rogers and Martire[73], it was found that depression is associated with greater self-reported disability than it is predicted by performance measures. It has been established that major depressive disorder is a chronic, lifelong illness; the risk for repeated episodes exceeds 80% in which patients may experience an average of four lifetime major depressive episodes of 20 weeks duration each[81].

Pressure continues to mount from insurers, employers and clients for occupational therapists to provide quality, evidence-based therapy services at the lowest possible cost[83]. Existing legislations also force employers to implement the relevant acts while handling the cases of sick or disabled employees. Practices of occupational therapists are expected to provide quality service while performing WCE of employees suffering from MDD.

2.4 South African legislation

The Employment Equity Act (EEA) and Technical Assistance Guidelines (TAG) define people with disabilities as ñpeople who have a long-term or recurring physical or mental impairment which substantially limits their prospects of entry into, or advancement in, employmentò[90](p.8). This statement states that people with disabilities have limited chances of being employed. The definitions of disability are varied, but the focus is on people with physical disabilities[36]. This is interesting as many organisations employ a wide range of people with disabilities, and yet they choose to focus on the physical aspect of disability[36]. Four out of ten employers would consider employing people with mental health problems, compared to six out of ten who would contemplate hiring someone with a physical disability[7].

Major depressive disorder is considered a mental illness with mental impairments. Employees with MDD tend to experience prejudice or the risk of dismissal due to their presenteeism and high absenteeism in the work place[7]. The challenge is that some employers consider MDD as madness, which leads to stigmatisation and discrimination[7]. It is also clear that the effectiveness of the Employment Equity Act is minimal. In fact, national departments attained only 0.47% against a target of 2% employment rate of disabled people in the public sector [36]. The main perception on the part of those with disabilities is that abled-bodied employees and managers frequently have a judgemental and dismissive attitude towards people with disabilities[36].

South Africa has some of the most comprehensive legislation and policies protecting and promoting the rights of disabled people in the work place[36]. Estimates of the number of persons with disabilities in South Africa vary from 5.9% to 12%[36]. Legislation that provides guidelines and policies to enforce the rights of ill employees includes:

- Constitution of the Republic of South Africa, No. 108 of 1996[91];
- Employment Equity Act (EEA), No 55 of 1998[47];
- Labour Relations Act (LRA), No 66 of 1995[92];
- Employment Equity Act (EEA), No 55 of 1998, Code of Good Practice on the employment of people with disabilities No 23702 Vol.446 of 2002[47];
- Technical Assistance Guideline (TAG) on the Employment of People with Disabilities Aug 2002[90];
- Promotion of Equality and Prevention of Unfair Discrimination Act, No 4 of 2000[93];
- Promotion of Access to Information Act, No 20 of 2000[94];
- Skills Development Act, No 97 of 1998[95];
- Basic Conditions of Employment Act, No 75 of 1997[96];
- Mental Health Care Act, No 17 of 2002[21];
- Occupational Health and Safety Act, No 85 of 1993[97].

The rules and policies are developed to ensure the protection of employees and employers for a healthy workplace[98].

The Code of Good Practice: Dismissal (CGP: D) contained in the Labour Relations Act (LRA)[92], deals with some of the key aspects of dismissal for reasons related to conduct and capacity. It has guidelines for poor work performance due to incapacity and guidelines in cases of dismissal for poor work performance and incapacity due to ill health. It stipulates that incapacity on the grounds of ill health or injury may be temporary or permanent. If an employee is temporarily unable to work in these circumstances, the employer should investigate the extent of the incapacity or the injury. In cases of permanent incapacity, the employer should ascertain the possibility of securing suitable alternative employment, or adapting the duties or work circumstances of the employee to accommodate the employeeôs disability[92,99]. Code of Good Practice: Dismissal explains that employers, who have employees that suffer from major depressive disorder, will need to refer their employees to mental health care practitioners including occupational therapists to evaluate of the extent of the employees incapacity to work[92].

The Labour Relations Act[92] (1995) encourages fair labour practices and non-discrimination in workplaces along with reasonable accommodation of disability or illness. The affirmative action measures contained in the Employment Equity Act allow people with disabilities to be given preference in the implementation of staff training programmes[47]. The Skills Development Act[95] (1998), in principle, makes it easier for people with disabilities to develop themselves in the work place. It facilitates the achievement of equity targets and caters for the needs of company employees including people with disabilities. If there is poor performance from an employee with major depressive disorder, the employer needs to assess if it is related to ill health or misconduct and whether there is a need for further training after the employee has been counselled.

The Code of Good Practice contained in the Employment Equity Act[47], stipulates that if the employee has been ill or injured, and it appears that he/she is not able to perform the job, the employer may require the employee to agree to a functional determination of disability. Such medical or appropriate tests shall be used to determine if the employee can safely perform the job or to identify reasonable accommodations required for the employee. The occupational therapists with their knowledge of work capacity evaluation are the relevant mental health care practitioners to assist with some of the tests and reasonable accommodations in the workplace.

The inclusion of disability in the South African Constitution has impacted, either directly or indirectly, on the lives of people with disabilities in the country, and has created opportunities to address inequalities experienced in the past[36]. Equality includes the full and equal enjoyment of all the rights and freedoms irrespective of illness, such as major depressive disorder in this instance.

The Promotion of Equality and Prevention of Unfair Discrimination Act[93] (2000) provides for measures to facilitate the eradication of unfair discrimination, hate speech and harassment, particularly on grounds of race, gender and disability. Some employees with major depressive disorder reports experiencing unfair discrimination and harassment as a result of their mental illness. The emotional tone or work atmosphere may produce negative perceptions when there is interfering office politics, a lack of effective consultation, exclusion from the decision-making process and restrictions on behaviour[76]. The act empowers the mental health care practitioner (occupational therapist) to be an advocate for the employees with major depressive disorder in their workplace.

The Employment Equity Act[47] (1998), refers to the inclusion of reasonable accommodations, stated as adaptations in the LRA. These measures require employers to make reasonable accommodations for disabled people to be able to carry out their essential functions of a job[7] and these accommodations must not cause any undue hardship to the employer.

The occupational therapist is the appropriate health care professional to assist the employer in determining if the employee is temporarily or permanently unable to work by carrying out WCE and by recommending appropriate reasonable accommodations. Examples of reasonable accommodations include making facilities accessible, restructuring the job/re-assigning the task, suggesting special equipment or devices, modifying administrative procedures and providing assistance or support[47]. Most reasonable accommodations for workers with psychiatric disabilities are inexpensive or free[100]. The accommodations most often recommended for employees with psychiatric disabilities are: provision of self-paced workload, flexible work schedules, longer or more frequent work breaks, time off for therapy, or job restructuring to eliminate or exchange auxiliary job functions that increase pressure for the worker and should include only essential functions[7,100].

A strong commitment from top-level management is crucial to the success and implementation of reasonable accommodations[99]. Reasonable accommodation is applicable only to the match between an individual disabled worker and a specific employment setting[100].

Depression is prevalent, and the cause of this depression may be ascribed not to the persons living with disability but to the lack of emotional connection and accommodation given to them at work.

Occupational therapists with their knowledge of mental health, adapting the work place, disability assessment and activity analysis (specifically work related activity) are in a unique position to evaluate employees with mental disability. They can help to establish the effect that their mental disabilities may have on their functioning in the work place and assist the employer in recommending appropriate adaptations for the employeeôs duties or suggesting the appropriate alternative work that will be relevant to the employeeôs abilities.

Occupational therapists have enhanced their professionôs profile, added significant value, developed, and marketed client-focused services and solutions, at the same time promoting the spirit, intent[101] and well-being of employees suffering from MDD. They are also in a better position to assist the employers regarding the employeeôs mental fitness to work. This shows that occupational therapists are ideally placed and uniquely skilled to deal with the challenges of the legislation and as such can be key role players in the work place by facilitating employment of people with disabilities and retaining them[102].

2.5 Work Capacity Evaluation

2.5.1 General aspects of Work Capacity Evaluation

Functional Capacity Evaluation (FCE) [1-4], Physical Capacity Evaluation (PCE)[1], Work Capacity Evaluation (WCE) [1,3,5-7] and Functional Capacity Assessment (FCA)[1] are terms that have been used interchangeably with Work Assessment in return-to-work programs. Functional Capacity Evaluation (FCE) is defined as a systematic, comprehensive and objective measurement of a personôs maximum work ability[4]. It is primarily a measure of

activity and activity limitations, or occupational performance of a client, used to make recommendations for participation in work or the worker role taking into account the personôs impairment, environment and other influencing factors[42]. Work may be identified in four different forms: paid work, unpaid work, hidden work and substitute work[7]. Many of the assessment techniques employed for FCE/WCE have been developed in the field of occupational therapy, physical therapy, ergonomics and sport medicine[4]. Occupational therapists and physical therapists appear to have been the first health care professionals to perform FCEôs/WCE[2], and are the most common providers of rehabilitation services[103].

Occupational therapists have long been proponents of functionally orientated assessments of capacity for work[42]. Functional Capacity Evaluation is one of the most commonly offered services in the provision of work rehabilitation by occupational therapists[42].

In this history of functional assessment for work and the common use of FCE/WCE in current practices, occupational therapists have not played a major role in FCE/WCE research and development[42]. These therapists have traditionally evaluated function, performed task analyses, and have an educational background that provides an understanding of pathology, and the musculoskeletal system, including muscle function and movement patterns[2]. The length of time to administer FCEôs varies among designers[2]. One FCE/WCE is administered over a two-day period[2,104,105]. It is recommended that the standard FCEôs be four to six hours in length[2,106] and they must assess general work demands such as lifting, carrying, reaching, sitting, standing, walking, as well as hand strength and coordination[2]. To meet consumer demands, an FCE should be conducted in one session. However, it is stated that the most reliable format for conducting an FCE is over a two-day period, with the most critical tasks being repeated on the second day[2]. The two days allow for retesting for accuracy and for evaluating the effect of the first dayôs assessment on the client[2], through the use of multiple methods for triangulation or comparison of information[105].

Work Capacity Evaluation includes participation as it relates to society, work performance as it relates to the client and the clientsô capacity as it relates to physical and psychological functioning[107].

Occupational therapists function as one of the mental health care practitioners who conduct WCE. In order for clinicians to select and conduct work-related assessments that demonstrate

best practice, it is necessary to identify assessments that are considered excellent[106]. There are many different approaches to FCEôs/WCEôs[105]. To date, there are no empirical studies that compare one approach to another in order to identify the best[105]. There have been a number of criteria or standards They aim to use standardised measurement tools that have demonstrated reliability[1,2,6,13,104-106,108], validity[1,2,6,13,104-106,108] safety[1,2,6,13,106,108] usefulness (utility)[1,6,108] recommended in selecting and evaluating work related assessments[106]. practicality[1,2,6,104,106,108], sensitivity and objectivity[1,2], all of which contribute to timely, clear and logical report formats[1]. These criteria have been summarised and interpreted as the attributes of safety, reliability, validity, practicality and utility and are frequently cited in relation to Functional Capacity Evaluation or Work Capacity Evaluations[106]. Practice guidelines also comment on the need for accuracy, comprehensiveness, objectivity, consistency, relevance, reproducibility, clinical utility/usefulness, generalisability, ecological and clinical validity, flexibility and standardised techniques and protocols[106].

Two major constructs are utility and dependability. Utility comprises qualitative attributes (accurate, comprehensive, credible, flexible, practical, relevant and useful) and is associated with broad concepts of validity, while dependability comprises quantitative attributes (consistent, measurable, objective, reliable, reproducible, standardised, structured and valid) and reflects concepts of reliability. Safety is essential for all assessments[106]. An approach to work-related assessment that combines qualitative and quantitative data sets is becoming more the expectation and norm[105] hence the application of similar approach in this study.

An FCE/WCE is not a stand-alone evaluation. Rather, an FCE/WCE consists of an interview, and clientôs history, a physical examination, test components, and a comparison of clientôs abilities with the demands of the job[2]. These evaluations begin by obtaining a comprehensive history of the individualsô occupational performance related to activities of daily living, work and to identifying the individualôs work-related behaviours, interests, abilities, needs and goals[1]. This serves as a baseline assessment of the individualôs physical/mental abilities to perform a variety of tasks related to the physical and mental demands of work and to compare functioning over time. There is a need for measures, which can provide information about affective well-being, subjective competence and aspiration, through scores, which can be compared with known means and standard deviation from appropriate demographic groups. However, without sound clinical reasoning and critical thinking, assessment results remain uni-dimensional and lacking in relevance to employees and their future[105]. Table 2.2 below

illustrates some of the general evaluation tools (standardised measures and non-standardised assessments) that are used by occupational therapists to perform WCE as discussed in different literature reviews:

Table 2.2: Standardised measures and non-standardised assessments for WCE

Standardised measures	Non-standardised assessments
• Cognitive Assessment of Minnesota (CAM)[107]; • Assessment of Motor and Process Skills (AMPS)[14,74,78,83,107,109]; • Therapistôs Portable Assessment Laboratory (T/PAL); • Work Ability Screening Profile (WASP); • Modular Arrangement of Pre-determined Time Standards (MODAPTS)[111] work sample for lifting, carrying, climbing and writing; • Rivermead Behavioural Memory Test[83,107]; • Hospital Anxiety and Depression Scale (HADS)[111]; • Beck Depression Inventory (BDI)[74,111]; • Bay Area Functional Performance Measure (BaFPE)[44,113]; • Mini-Mental Status Examination (MMSE)[74,107]; • Jamar Hand Dynamometer[105]; • Hamilton Rating Scale for Depression[105,113,114]; • Baltimore Therapeutic Equipment (BTE)[7]; • Canadian Occupational Performance	• Structured interview[2,6,13,14,78,83,105,110,111]; • Activities (structured and unstructured)[1,3,12,83,110]; • Clinical Observation[1,3,7,14,78,105] • Collateral information[1,3,7,15,52]; • Job analysis[112].

Standardised measures	Non-standardised assessments
Measure (COPM)[7,105,112,113]; • Zung Self Rating Scale[104,113]; • The Visual Analogue Scale[26,1111]; • Heart rate monitor[2]; • Blood pressure[2].	

Craik, Chacksfield and Richards[18] give an instructive observation regarding use of standardised measurements in mental health when they write that:

> ñSeventy-four (54 %) of respondents did not report using standardised assessments measures. The preferred assessment was the Canadian Occupational Performance Measure (COPM) with twenty-four (18%) of the total sample using it. Thirty-six therapists (26%) of the total sample used its companion the Canadian Occupational Performance Model. Fourteen therapists reported using The Assessment of Motor and Process Skills (AMPS) and seven identified Occupational Case Analysis and Rating Scale (OCARIS) in contrast to the 68 therapists (50%) who used Model of Human Occupation (MOHO), the model from which these assessments were derivedò (p.232).

This citation will help this study compare the standardised measurements used elsewhere with those in South Africa.

The following occupational performance (performance skills and areas of occupation) are important and need to be considered by occupational therapists while assessing employees who suffer from MDD. Usually an evaluation consists of the assessment of performance skills such as emotional state, personality, conation and cognitive factors (intellect, memory, attention, concentration, problem solving and learning skills) and self-concept[8]. The selection of standardised measures aims to measure different aspects of memory, attention and executive functioning[115]. The areas of occupation consist of ability to engage in activities of daily living, leisure activities, social participation, work habits and vocational skills[2].

Major depressive disorder is significantly associated with greater self-reported disability, and is significantly related to lower maximum weight lifted during a progressive isoinertial lifting

task[4]. The most significant predictor of functional disability is severity of symptoms[24]. A study based on data from samples of persons with a range of chronic illnesses indicated that depression exacerbates and affect poor physical functioning[4]. The connection between depression and the experience of pain may be part of the reason for worse functional outcome[68]. Work disability arises from complex interactions between the work environment and the individual within it[116].

2.5.2 The significance of Work Capacity Evaluation

Work Capacity Evaluations are used for a variety of reasons. One can use a WCE/FCE to develop a treatment program, to measure the physical abilities of patients before and after a rehabilitation program, to modify a rehabilitation treatment, to evaluate whether an injured/ill worker can work, and to determine when he/she can return to work[37]. The outcomes following a comprehensive WCE/FCE include the following as stated by Buys and Biljon[111]:

i. ñReturn to work (with the same or alternative employer) with or without the implementation of reasonable accommodations.
ii. Determination of appropriate work place accommodation and adaptations.
iii. Referral to intervention programs such as work hardening and work preparation programs.
iv. Case management.
v. Application for government disability grant.
vi. Placement in supported, sheltered or protective employmentò (p.32).

Functional Capacity Evaluation or Work Capacity Evaluation is a significant tool that can be used to make an objective and subjective assessment of the individualôs condition[1]. The role of FCE/WCE appears to be increasing as employers, legal professions and insurers rely more heavily on them for decision making[2]. The FCE has become a widely used tool for determining a personôs readiness to return to work after injury or illness, for performing pre-employment and post-offer screening, and for making disability determinations[2]. The FCE/WCE tools need to show some reliability (stable scores over time) and validity (it should measure what it intends to measure and is plausible)[37]. The question of who is

qualified to administer FCE/WCE is addressed by determining the competencies required to perform a safe, reliable and valid FCE/WCE[2].

The construct of Work Capacity Evaluation describes an individualôs ability to perform work tasks on a safe and dependable basis[6]. It is a complex construct that encapsulates many different abilities as they apply to work tasks[6]. These abilities are measured and compared to tasks demands in order to determine the likelihood that the individual will be able to perform the tasks with reasonable safety and dependability[6]. Therefore, Work Capacity Evaluation is the objective quantification of occupational disability[5,6]. The most useful factors for quantifying the occupational consequence of particular injury include the diagnosis (considering pathology and impairment together), work capacity, occupation and age of the worker[6]. The result of the examination may frame the work capacity of the worker in reference to a specific job or accepted occupational standard[39]. Jones and Kumar[39] mentioned that Functional Capacity Evaluation may be broadly categorized into three groupôs dependent on the desired outcome:

1. ñBaseline work capacity evaluation, which seeks to quantify the workers ability to perform the 20 job activities, described in the Dictionary of Occupational Titles.
2. Job capacity evaluation - specific job is known and the evaluation seeks to quantify the workerôs abilities in direct comparison to the identified critical demands of the specific job in question.
3. Work Capacity Evaluation - specific job not identified and the evaluation seeks to determine whether the worker is able to return to competitive employmentò (p.180).

Occupational therapists work with other professionals in addressing issues that affect an individualôs ability to work[107]. Ideally, a multidisciplinary team should be responsible for determining a personôs functional capacity. However, psychiatrists while assessing disability, express their professional opinions only on the degree of functional impairment and to indicate whether this is permanent or not and hardly comment on disability[35].

The general practitionerôs records are useful to the multidisciplinary team in providing evidence of diagnosis or health conditions, but less useful for judging functionality. Their reports are found to be more accurate, more objective and with more up-to-date clinical

information[36]. In one study, 61% of doctors surveyed reported little contact with the workplace[103].

Attributes contributing to the occupational therapy professionôs suitability for work practice included a bio-psychosocial approach to intervention, and a recognised competence in task analysis and environmental modification[103]. Given that occupational therapists use the bio-psychosocial approach in assessment and intervention, they are in a better position to assess the employeeôs level of work capacity. That being the case, general practitioners, psychiatrists, psychologists, insurance companies, government department of social services and employers refer employees who suffer from ill health to occupational therapists for Work Capacity Evaluation to ascertain employeesô capacity to work. South African occupational therapists have probably been involved in the delivery of work practice services since training began at the University of Witwatersrand in 1944[111].

2.5.3 Matching the employee with the job during WCE

Most comprehensive FCE/WCEôs include the physical demands of work as specified by the US Department of Labour in the Dictionary of Occupational Titles (DOT)[2,42]. The job factors listed in the DOT express both the physical requirements of jobs and the physical capacity a worker must have to meet those demands[2]. The DOT, developed in 1983[75], is a valuable resource in initially attempting to identify potential work opportunities[2].

A number of existing FCE/WCE approaches uses the DOT physical demand as a content source for the FCE/WCE[42]. The physical demands include standing, walking, sitting, lifting, carrying, climbing, kneeling, and crouching[42]. The physical demands from the DOT provide a source for a consistent framework of functional activities to be performed and observed in the FCE/WCE[42]. The DOT classifies occupations into sedentary, light, medium, or heavy categories based on the weight the worker is commonly required to lift and carry[39]. Three overall problems with the DOT were identified: (a) The information generated was very job specific, (b) Information contained in the DOT was becoming dated, especially given the accelerated pace of change in work and jobs in the past 20 years, (c) Focusing on the task level did not provide a cross-job organising structure[117]. This made it difficult to compare

similarities and differences across jobs. The DOT did not directly yield much information on the skills and knowledge required to perform the jobs[117].

The need for occupational information that is more relevant to the modern workplace spurred the creation of the O*NET[75]. O*NET is a database which allows everyone to access data on job characteristics and worker attributes[75]. It includes information on the knowledge, skills, abilities, interests, preparation, context, and tasks associated with 1,122 O*NET occupations[75]. O*NET addresses these issues by allowing the accumulation of jobs specific information, but doing so within the organising structure of the broader descriptors[7,117]. The O*NET abilities taxonomy[117] is in line with occupational therapy framework which makes Functional Capacity Evaluation or Work Capacity Evaluation holistic rather than focusing only on physical demands.

In this job matching approach, the FCE/WCE results are used to establish whether a worker is capable of performing the required job demands in order to facilitate return-to-work process[104]. Some employees have insufficient motivation to return-to-work for a variety of psychosocial and circumstantial reasons[88]. Their general practitioners, insurance benefits and other circumstantial factors[88] could reinforce their lack of motivation. The work rehabilitation process usually involves an assessment of the match between the demands of the workerôs job or workplace and the residual functional capacity of the worker, the results of which then guide interventions to address mismatch[42]. The importance of on-site observations when the client is performing their job best facilitates the emergence of occupation-centred, client-centred service[105].

Successful achievement of occupational roles is attained through the interaction of areas of occupation, their corresponding performance skills and the contextual environment[76]. An occupational therapy outcome is the functional consequence for the patient of the therapeutic actions implemented by an occupational therapist[83].

2.6 Occupational Performance

Function is the ability of a person to perform activities in a manner, which achieves the desired purpose[107]. It is acknowledged that function is influenced not only by injury to bodily

structure but also by environmental factors such as subject motivation and attitude[118]. The person who functioned well until the onset of a major depression that affects their level of motivation[119], has limited level of function in all areas of life, including work and leisure[109].

Functional ability is considered a dynamic interaction between bodily functions and participation in society[118]. Keough and Fischer[76] state that a lack of meaningful, purposeful activities cause a breakdown in habits further leading to psychological deterioration and decreased ability to perform optimally in daily life. Occupational therapists place emphasis on assessment of occupational performance (such as activities of daily living, work, play and leisure) or on the performance of actual roles (of worker, volunteer, homemaker, student, patient, spouse or friend) which were noticed to be higher in the functional assessment hierarchy in one study[42] .

Performance components (performance skills) are defined as the elements that make up or provide the ability to do activities[42] and they include sensory, motor, cognitive, psychological and neuromuscular abilities. Symptom measures alone provide moderate evidence for predicting vocational functioning or capacity among persons with severe psychiatric disability[120]. Functional Capacity Evaluation that is based on observation of the performance of physical demands of work as defined by the DOT can be classified as an evaluation of occupational performance in that FCE evaluates the personôs ability to perform work-related activities[42]. Performance skill assessment measure impairment, areas of occupation assessments measure disability and role performance assessment measures handicap[42].

The term functional limitation and impairment is synonymous with the term performance skill[105]. Deficits in areas of occupation would be activity limitations, deficits in role performance would be participation restrictions, and deficits in performance skills remain comparable to impairments[42]. Depression may in part result from imbalances of lifestyle and limitation of activity[119]. Depression is recognised when the personôs enjoyment of activity and activity patterns are suppressed[119]. Individuals with depression often experience low motivation, have difficulty in planning, exhibit self-neglect, have memory problems and poor attention, all of which compromise occupational performance[105]. Feelings of depression are typically associated with the belief that one lacks control to successfully master the environment[119]. Depressive disorders are not specifically identified based on functional change; performance is most often affected[74]. There is a definite need in the workplace for

occupational therapists to address the performance deficits in those individuals who suffer the effects of mental illness[107].

Dysfunction according to occupational therapy theorists emphasizes the relationship of emotion to action[74]. The Person Environment Occupational Performance Model identifies psychological factors as contributing to self-identity, and thereby to both well-being and occupational performance[74]. The Model of Human Occupation holds that someone who is depressed is lacking in valued goals and roles, or skills to achieve those goals[7,74]. The Occupational Adaptation Model theorizes that psychological dysfunction is the result of inability to adapt effectively during times of disequilibrium[74]. Depression is the result of inability to master a situation that called for change in performance[74].

It is commonly argued that one of the most important goals in the recovery process from mental illness of all kinds is to increase functional outcome[121]. By functional, is meant that one is able to participate in the basic activities of daily living, including the fulfilment of some, if not all, major life role obligations (e.g. getting on with life beyond illness)[29].

2.7 The return-to-work decision

2.7.1 Challenges in facilitating return-to-work decisions

National Surveys indicate that the percentage of persons with mental illness who are employed ranges from approximately 44% to 72%[68]. Schizophrenia and related conditions are associated with the lowest rate of employment, ranging from 22% to 40% in national surveys[68]. A survey found that employment rates are much lower among persons with a mental illness than among the general population[68]. The situation might be the same in South Africa, as national departments attained 0.47% of disabled people in the public sector[36] and majority of them will be people with physical disabilities as previously mentioned. Most people including those with severe mental illnesses, report that they want to work. It has often been argued that people are less likely to report being disabled once they are employed[48]. Data on labour force participation rates also indicate that people with

psychiatric disabilities are disproportionately excluded from employment when compared to persons with other types of disability[68].

Workplace characteristics such as the stigma associated with mental illness, the lack of accommodations, and labour market characteristics are the central barriers to employment among persons with mental illness[7,68]. Factors that influence the return to work status of the ill employee may include the length of rehabilitation, the various rehabilitation services provided and psychosocial factors (emotional well-being of an individual)[76]. Research suggests that there may be four types of barriers to employment among individuals with mental illness: (a) illness characteristics, (b) client characteristics, (c) access to service and appropriate mental health treatment, and (d) characteristics of the workplace and the labour market[68]. Forty-four per cent of employers indicated that they would be uncomfortable hiring someone who was in treatment for depression[68]. There is evidence that employed disabled people are more likely to be aware of their rights compared to non-employed[48]ones.

Health professionals have a key role to play in facilitating safe, effective and timely return to work, particularly since returning to work is hailed as an important part of an individualôs recovery[7]. Poor communication between health professionals has been found to act as a key barrier to effective rehabilitation for work[7] and thereby delaying the return-to-work decision.

2.7.2 Disability management during return-to-work process

Disability management represents the continuum of interventions identified as critical to returning injured workers to work and reducing costs[7,116]. The occupational therapist, who is involved in supporting clients through case management, may assist with transitions and adjustments to return-to-work[7]. These policies and practices would be consistent with a management perspective that views investment in people - through safety, health, and accommodation - as an equally important strategy to achieving the productivity and financial goals of the organisation[116].

A successful return-to-work is unlikely to be achieved without the co-operation and goodwill of the employer[7]. Management has a direct impact on the level of employee participation and may help achieve employee ambitions or goals[76]. These goals may include performing productive work, perceiving a sense of accomplishment or pride, and earning income to

support self and dependents[76]. A hostile work environment is a barrier to a successful return-to-work[7].

2.7.3 Factors that influence the return-to-work decisions

In some studies, social pressure was found not to be associated with the time to return-to-work (RTW)[122]. Most respondents reported no pressure from family, friends, supervisor and co-workers, caregivers and community regarding RTW[122]. If pressure was perceived it was mostly from supervisors[122]. Low supervisor support is associated with a higher RTW rate[123]. Low social support may act as an extra pressure to attend work[123].

In general, as duration of sick leave increases, the chance to return-to-work decreases[124]. Longer duration of sickness absence increases the risk of permanent disability, and thus creates a higher inflow into the disability benefit systems[123]. The following key factors influence the decision to return-to-work as suggested by Ross[7]:

1. ñMotivation to return to work;
2. Level of job satisfaction;
3. Occupational and worker identity;
4. The clientsô values and beliefs, and those of others around them;
5. The clientsô pre-injury/illness relationship with others at work;
6. The nature of the clientôs condition and their experience of illness;
7. The stage and pace of the clients recovery;
8. On-going complications such as pain and fatigue;
9. The length of time the client has been away from the workplace;
10. The demands and requirements of the clientôs job;
11. The nature of any identified risks;
12. The clientôs age;
13. The clientôs existing financial commitments;
14. Involvement in a legal process, and
15. Whether the clientsô condition is covered by the disability discrimination actò (p.130).

2.7.4 Return-to-work intervention programs

Interventions for persons with mental conditions are likely to be more effective if they occur early, rather than later in the course of disability[68]. Early intervention increases the chances of preventing long-term, severe work disability[68]. Rehabilitation remains the core area of service provision in work practice[103]. Vocational rehabilitation is a process whereby those disadvantaged by illness or disability can be enabled to access, return to, or remain in, employment or other useful occupation[7].

One important indicator of functional outcome is successful re-entry into the workforce, whether in a part time or full time capacity. The achievement of this outcome is one that requires attention not only to symptom reduction, but also to the physiological attitude of the individual towards their illness, its meaning and significance to them in the context of their life in general, as well as their work in particular[29]. A key member of the team is the worker, who must clearly understand that failure to participate in the rehabilitation process may result in loss of benefits[8]. In order to effect optimal performance at work, intervention must maximise the fit between the capacity of the worker and the demands of the job or workplace or both[103]. Safety is a paramount concern throughout the vocational rehabilitation (VR) process, and assessing risk is an important component of determining work readiness[7]. If the client has the existing job to return to, there are additional workplace factors that may also affect the feasibility for the return to work[7]. Ross[7] include the following factors:

1. ñThe availability of modified duties;
2. The employers existing return-to-work policies;
3. The size of the company;
4. The willingness of the employer for the person to return;
5. The perceived value of the person to the company, both in financial terms and in terms of their skills, abilities and role within the company, and
6. Their pre-injury or pre-illness attendance patterns and any outstanding capability or disciplinary issuesò (p.130).

Employees suffering from MDD who have returned to work report fewer symptoms of depression compared with employees who do not start working[77]. The return-to-work for

clients with disabilities has become an area for development in which occupational therapists can play a significant role[125]. The occupational therapist together with the client will need to identify possible strengths and barriers when reaching decision about readiness to return to work[7].

The decision to return to work needs to be based on the functional abilities (occupational performances) and limitations of each individual as they relate to his or her job situation[2]. In one context, functional outcome was a better predictor of ability to return to work than severity of the injury[125]. A Study by Gold and Shuman[24], report substantial positive correlation between symptom severity and impairment in work functioning. An individual is said to be occupationally fit if the physical and cognitive job demands are within his/her working capacity[8]. Occupational therapists can play a major role in the work rehabilitation process through assessment and rehabilitation of workers with disability for return-to-work (RTW)[42]. This holistic approach enables the employer and industrial health care professionals to work together to provide a safe, worker-friendly, supportive environment that maximises productivity and meets organisational goals[76]. Barriers in returning to work often arise from personal, work or family related problems, rather than from the original health condition itself[124]. Dionne, Bourbonnais, Fremont, Rossignol, Stock, Nouwen[126], cite a study by Baldwin (2005) who identified four mutually exclusive patterns of return to work among injured workers: success on first attempt to return-to-work, failure without any attempt to return, several attempts ending by a successful return to work and several attempts ending by a failure to return to work.

Flexible work hours, unpaid leave days, and flexibility in job assignment are among the accommodations that have been suggested to be potentially helpful[68]. Others have focused on the interpersonal or social context of the workplace, and argued that accommodations that address the social nature of work are likely to be most important for persons with mental illness[68]. For example, supervisors and co-workers can be educated to increase their understanding of the symptoms of mental illness.

Return-to-work programs can be loosely classified as either prevocational training or supported employment. The prevocational training model includes such programs as clubhouses, skills training, sheltered employment and transitional employment[68]. The goals

of group sessions and individual sessions are (1) reintegrating clients at work, (2) improving their ability to cope effectively with stress situation at work (3) increase their work satisfaction, and (4) preventing the new depressive episode[77]. Under this model, resources are devoted to preparing the individual to be ready for work. Supported employment programs have been developed and expanded as an alternative to prevocational training[68]. Establishing an environment of no blame helps to keep efforts on the ill workers return to work rather than where faults lie[76]. Some research results also demonstrated that those clients who had gone through a coordinated system and had had contact with a vocational case manager were significantly more likely to return to some form of employment or training than those who had not[125].

In evaluations where return-to-work is the major focus, a job analysis should be performed to determine the tasks required for the job[2]. The results of the FCE can be compared with the jobôs physical and psychological requirements[2]. It must be acknowledged that there is limited evidence to support the relevance of peopleôs performance of the physical demands from the DOT to RTW[42]. Return-to-work can be conceptualized as a complex human behaviour change, with the employee taking the final decision to return to work[122]. Two different studies agreed that a positive attitude to return to work, high social support and a high level of self-efficacy are all positively associated with RTW[122,124]. The three main work-related predictors of RTW are vocational sector, supervisor support and co-worker support[123]. A trusting relationship between the worker and all concerned parties is a prerequisite to successful RTW[8].

2.8 Conclusion

It was thought provoking to note in the literature that MDD will be a disease burden in the near future, which will have a negative influence on employeesô work habits and work productivity. This shows that occupational therapists need to equip themselves to competently assess and treat MDD. They need to ensure that their WCE tools meet the attributes of safety, reliability, validity, practicality and utility. They also need to ensure that they apply their knowledge of ñprofessional reasoningò[112] (p.314) throughout the WCE process. This will help towards accelerating the speed of return-to-work programs and reduce unnecessary paying out of disability benefits.

2.9 Summary

In this chapter, the diagnosis of major depressive disorder and its implication to the society, economy and employers were discussed. The ways of performing work capacity evaluation with the aim of returning employees suffering from major depressive disorder to work, were also deliberated on. Chapter 3 presents and discusses the research methodology of the study.

CHAPTER 3

RESEARCH METHODOLOGY

3.1 Introduction

This chapter discusses the different designs used to administer this study and the reason for their choices. Research designs are tailored to address different kinds of questions[65]. The researcher noted that both qualitative and quantitative enquiries would be suited for this study since they can be used complimentarily, each adding value to the credibility of the study[127]. The researcherôs aim was to seek understanding into participantsô perspectives and experiences regarding the performance of WCE on employees suffering from MDD.

This chapter focuses on the research designs, selection of participants, data collection methods in different phases, techniques used for data analysis and measures to ensure trustworthiness and credibility of the study.

3.2 Research design

In order to gain a nuanced understanding of a research topic, the researcher, where applicable, should use more than one method of study[128]. The mixed methods design was chosen because of its complementary effect. Both qualitative and quantitative approaches were used. The mixed methods approach is defined as a procedure for collecting and analysing, mixing both qualitative and quantitative data at some stage of the research process within a single study to understand a research problem[61,129].

The mixed methods suggest that phenomena are best understood if they are viewed from various perspectives[127]. In other words, the combination of methods is often the most effective way to extend the researcherôs insight into the research question[130]. It divides inquiry into dichotomous categories: exploration versus confirmation[63]. ñThe qualitative

method is designed to investigate meaning and subjectivityò[131] (p.169) while the quantitative method is useful for its ñgeneralizabilityò[127] and ñobjectivityò[130].

A mixture of qualitative and quantitative methods is categorised as complex since it involves multiple types of data collected at different times[132]. This study design is divided into four distinct phases. It comprises the initial phase of collection and analysis of qualitative data (descriptive questions), followed by collection and analysis of quantitative data (close-ended questionnaires) in phase two, then; the collection and analysis of qualitative data (focus group interviews) in phase three and finally, member checking in phase four for confirmation of data obtained in phase three. This is referred to as the sequential exploratory strategy with elements of embedded design[60,129]. Following this mixed design enhanced the researchersô understanding of the perceptions and practices of occupational therapists in determining work capacity evaluation of employees suffering from MDD. The qualitative enquiry is given priority in this study. The status of this mixed methods research design is referred to as ñfully mixed sequential dominant status-qualitative designò[133] (p.296), where quantitative and qualitative phases occur one after the other, with the qualitative phase being given higher priority and mixing occurring within data collection, analysis and interpretation stages.

In phase one, the descriptive questionnaire (qualitative data) provided organised and systematic data on occupational therapistsô perceptions on Work Capacity Evaluation (WCE). These data were essential to guide the researcher and some of the data were used for confirmation purposes through a questionnaire in phase two, and for validation and consecutive phenomenological enquiry in phase three and confirmation of data using member checking in phase four.

The quantitative approach required the use of standardized measures so that varying perspectives and experiences of people could fit into the limited number of predetermined response categories to which numbers were assigned[134]. The quantitative approach has its roots in logical positivism and focuses on measurable aspects of human behaviour[135].

The qualitative approach facilitated an in-depth study of issues. Qualitative researchers study the concepts in their natural settings, attempting to make sense of phenomena in terms of the meanings that the participants bring[136]. It approaches fieldwork without being constrained by predetermined categories of analysis and contributes to the depth, openness, and details of

qualitative inquiry[60]. It has its roots in symbolic interactionism, or phenomenology, and concentrates on qualitative aspects such as meaning, experience and understanding[134]. The mixed design enhanced the researcherôs understanding of the perceptions and practices of occupational therapists.

3.2.1 Qualitative approaches

3.2.1.1 Characteristics of qualitative approaches

Qualitative research is characterised by six principles[61,135]:

i. Believing in multiple realities. The researcher used descriptive questions, field notes and focus group interviews to capture multiple realities.
ii. Being committed to identifying an approach to understand the phenomenon studied. In Chapter 4, the researcher discusses the findings in light of the extant literature on the research topic.
iii. Being committed to the participantsô viewpoints. During the focus group interview, the researcher respected each participantôs viewpoints.
iv. Conducting the enquiry in a way that limits disruption of the natural context of the phenomenon of interest. In this study, the research made use of bracketing.
v. Acknowledging the participants in the research process. Each participantôs attendance and participation was taken seriously.
vi. Reporting the data in a literary style rich with participantsô commentaries. This is illustrated during the discussion of findings.

3.2.1.2 Advantages of qualitative study

In qualitative research, there is a need for developing an initial understanding of the phenomenon[65]. With reference to this study, the researcher strove to understand the interpretation of Work Capacity Evaluation and the perceptions and practices amongst occupational therapists. This means multiple realities (group-shared reality) were compared with individual personal reality, and more emphasis was placed on the participantôs

perspective and description of events, beliefs and behaviours. This made it possible to generate very rich data.

3.2.2 Quantitative approaches

3.2.2.1 Characteristics of quantitative approaches

The characteristics of quantitative research approaches are as follows:

i. The research design provide valid and reliable evidence[57] by using statistical analysis.
ii. The researcher asks specific, narrow research questions[129]. In this study, the researcher asked close ended questions in phase two.
iii. Quantitative research allows for generalizability of results to the whole population[57,129] in this study, occupational therapists.
iv. The researcher controls for personal bias by selecting reliable and valid measures. The researcher used the closed questionnaire that for the most part is reliable and valid[129].

3.2.2.2 Advantages of quantitative study

Quantitative designs are (1) objective, (2) gives numerical data (3) and generalizability of the findings[129].

3.3 Research strategies

It was clear that in order for the research to be genuinely phenomenological and scientific, it would have to meet two sets of criteria: phenomenological and scientific[137]. Within a continental phenomenological perspective, a scientific researcher would have to be descriptive in the search for multiple meanings[137] to the participantôs experiences. Although the study relied upon observations for the acquisition of data, data had to be organised and presented systematically so that valid and accurate conclusions could be drawn.

3.4 Phenomenology

The phenomenological strategy was used during the qualitative approach. Phenomenological research is described ñas the study of essenceò[57,134] since it possesses ña certain intrinsic sense of the truthò[138] and it describes the meaning of several individualsô lived experiences of a concept or phenomenon[61]. The interpretive paradigm (Hermeneutics) and descriptive phenomenology were appropriate for addressing the research question and the phenomenon under investigation[139]. Hermeneutic phenomenology describes the experiences as they are lived by the participants[61].

The phenomenological approach is discovery oriented, and in order to discover meaning in the data, the researcher needs an attitude open enough to let even unexpected meanings emerge[137]. One of the appealing aspects of phenomenology is its comprehensiveness[140] in describing the common experience of the phenomenon amongst the participants[61].

This comprehensiveness can be seen in the fact that phenomenology always starts from the perspective of consciousness and allows that whatever presents itself to consciousness, precisely as it presents itself, is a legitimate point of departure for research[140]. The study of phenomenology is concerned with the representation of knowledge as conscious experience[141]. A phenomenon is present when its meaning is expressed; regardless of the form, it takes[140]. Within a phenomenological strategy, a more precise meaning is given to the word óexperienceô[137,141] which interrogates everyday knowledge[141].

Therefore, phenomenology is an approach that concentrates on a subjectôs experience rather than the participant as a subject or object[64]. The phenomenologist remains centred on eliciting the experience of participants so that the phenomenon can be revealed[142].

Thus, phenomenological reflection is retrospective[134]. The phenomenological stance, then, is that it is more rigorous to acknowledge the role of consciousness and take it into account than it is to ignore it[137]. It is concerned with the participantôs subjective reports rather than the formulation of objective accounts, and it recognises that research is a dynamic process[143].

In this study, the phenomenon being studied were the perceptions and practices of occupational therapists in determining work capacity, and the researcher wanted to understand the perceptions of occupational therapists doing work capacity evaluations with employees suffering from major depressive disorder. The researcher related with the participants to get their knowledge on this subject. As Patton[134] observes that phenomenologist searches for common human experiences and rigorously use the method of bracketing to search for those commonalities. The experiences of different participants were bracketed, analysed and compared to identify the essence of the phenomenon[134]. The researcher had personal experience with an intense interest in the phenomenon under study. With regard to this study, the researcher has been working in the field of mental health and performing vocational assessments for 16 years. He has personal experience and interest working with employees suffering from major depressive disorder, and constantly performing work capacity evaluations with some employees to determine their return-to-work potential. The researcher ensured that he bracketed himself since he works in the field of mental health and vocational rehabilitation. In this study, the researcher tried to find the truth from experienced occupational therapists.

3.5 Study population

The study population included occupational therapists registered with the Health Professions Council of South Africa (HPCSA) and who work in the field of vocational rehabilitation and/or mental health.

3.5.1 Phase one: Descriptive questions

Descriptive questions require expansion[144]. Expanding descriptive questions not only gives participants time to think, but it also says, ñtell me as much as you can in detailò[144] (p.50). Descriptive questions are concerned with the description and/ or summarisation of the data obtained from a group of individual participants[145].

While designing the descriptive questions, the researcher considered the research aim and objectives of the study and listed the questions trying to answer the research question[58].

Descriptive questions were intended to encourage the participants to write about their modes of practice[144]. The researcher used open-ended questions to elicit rich data.

The advantage of open-ended questions is that they allow the participants to respond freely in their own words and in the process provide richer information[57]. In this study, the researcher devised self-completed questionnaires[58]. He then mailed/posted open-ended general experience questions (see Appendix 1). The reason for posting the questionnaire was to achieve anonymity of participants who were identified from a database of the occupational therapy graduates who completed the Post Graduate Diploma in Vocational Rehabilitation at the University Of Pretoria (UP). The University of Pretoria is the only university in South Africa that offers the Post-Graduate Diploma in Vocational Rehabilitation. Permission to access the database was obtained from the Head of the Department of Occupational Therapy, University of Pretoria. There were 69 graduates from the year 1998 to 2006. The researcher did not manage to get the contact details (addresses, cell phone numbers and e-mails) of 9 graduates resulting in the posting of the questionnaires to 60 graduates. The questionnaires were posted with self-addressed and stamped envelopes. The researcher followed up with 20 e-mails from the same number of e-mail addresses that he had. The Occupational Therapy lecturer in vocational rehabilitation sent 20 e-mails from the University of Pretoria to her post-graduate students as a follow-up as well.

Experience questions merely asked the participants for any experience they had in some particular setting[144] such as performing work capacity evaluation in their practices. The researcher reminded the participants weekly by sending mobile phone text messages to encourage them to complete and return the questionnaire before the 30th September 2007. Since the response was very slow, the researcher had to extend the completion date of descriptive questions in Appendix 1 to the end of December 2007.

The questionnaire in Appendix 1 contained demographic information (gender, age, place of work, province of work, post-graduate diploma completion date, province of work and years of experience), as well as 15 open-ended questions. The open-ended general questions allowed the participants to answer from their own frame of reference and to express their thoughts freely. A Consent Form was attached to the questionnaire. The responses were anonymous since the participants were asked not to provide their names. The researcher numbered the completed questionnaires as they were received.

One of the key advantages in asking descriptive questions was that through their openness, they encouraged long and detailed responses[144].

In spite of the researcherôs use of e-mails and text messages from mobile phones to ensure a good response rate from the respondents, only 28 responses were received (22 e-mails and 6 posted) of the descriptive questions in phase one (Appendix 1). It was a poor response rate of 46.7% since more than 50% is regarded as a good response rate[129,146]. Despite the response rate of less than 50%, the information received by the researcher was sufficient to be able to continue with phase two.

The findings of the descriptive questions from Appendix 1 were categorised into themes (refer to Chapter 4). The data were ranked according to their frequency and utilised as a basis to develop a close-ended questionnaire (Appendix 2), for confirmation of findings. Some of the open-ended questions (Appendix 3) were discussed in the focus group interview for further clarification.

3.5.2 Phase two: Close-ended questionnaire

The close-ended questionnaire had six grouped statements and the researcher used Likert scaled responses/response alternatives[64,129] where the participants had to tick ñyesò, ñnoò, ñuncertainò, ñagreeò or ñdo not agreeò(Appendix 2). As Maree[129] observes the agreement scale is the most common Likert scale used. The participants completed the questions themselves[57]. Close-ended questions were the preferred option to determine if participants agreed with the statements on the questionnaire in Appendix 2.

The researcher used pre-coded questions to limit the range and complexity of participantsô answers[58]. There were three reasons for pre-coding the questions as clarified by Buckingham and Saunders[58]:

1. ñIt makes it easier to record the information. It was simpler, quick and easier for the participants to tick an item than to write out an answer.
2. It saved time later as data is manageable during the analysis.

3. It ensured the data that the researcher wanted. It allowed each participant to give an answer that can be measured and compared on a common dimensionò (p.74).

This benefits of pre-coding the questions were helpful and applicable to this study. A consent form was sent with the questionnaire. Fifty questionnaires were posted to participants who did not take part in the first phase and they did not require Post-Graduate Diploma in Vocational Rehabilitation. The participants needed clinical exposure in vocational rehabilitation and/or mental health. The reason for using different participants is that the researcher wanted to see if there was consensus with the findings of the first phase (Appendix 1). The participants were selected from the Occupational Therapy Association of South Africa (OTASA) directory of occupational therapists in private practice working in the field of vocational rehabilitation and/or mental health and practice throughout South Africa. The OTASA office was also requested to send e-mails to the same population. Twenty-nine responses were received, with a response rate of 58%.

The purpose of fixed alternative questions was to ensure comparability of responses and to facilitate analysis[57].

3.5.3 Phase three: Focus group interview

In areas of study where little is known, focus group interviews may be an appropriate place to begin[63]. As a qualitative method for gathering data, focus group provides ideal opportunities to hear from several participants at one time[62,139]. It is an efficient way to hear respondentsô views, experiences and opinions quickly.

The focus group interview is a discussion group of eight to 12 participants, it focuses on a particular topic of interest, that is facilitated by a trained researcher[128] or six to 10 participants or five to 10 participants whose opinions and experiences are solicited simultaneously[57] in a group[136]. From the different studies mentioned above, it is clear that focus group interviews consist between five to 12 participants. It was noted that eight-member groups generated significantly more ideas than four member groups[128]. Morgan[62] identifies three different types of focus group according to their knowledge that is sought: exploratory, clinical and phenomenological. The one in this research was phenomenological as it gave the researcher

access to the participantsô common sense conceptions and everyday explanations[62]. The basic requirements of the phenomenological focus group interview is the interest that the researcher has for othersô stories or experiences[142], in this case, occupational therapists.

The objective of the focus group interview was to get high quality data in a social context where people could consider their own views in the context of otherôs views. Group members influence each other by responding to the ideas and comments in a discussion[134]. The advantage is that the dynamics of the group are an integral part of the procedure with participants interacting with each other during the discussion rather than directing their comments to the moderator[129]. Beyers and Wilcox[128] make an instructive observation that ñthe focus group interview could be useful by itself as a self-contained method of research or it could be used as part of an on-going, multi-method study when used in conjunction with surveys or participant observationsò (p.65). This method was used to elicit in-depth information from the participants[128].

The focus group interview used in this research study was semi-structured[57,64,113] since it allowed the participants to answer a set of pre-determined questions[129]. During the semi-structured focus group interviews, the researcher used an interview guide that could be adapted as necessary during the interviews[57,113,142,143,147]. The semi-structured interview, as Maree[129] notes is commonly used in research projects to corroborate data emerging from other data source. In this study, it emerged from the descriptive questions in the first phase of the study. Most of the questions were open-ended.

The purpose of the focus group interview is to promote self-disclosure amongst participants[65]. It is to know what people really think and feel about the topic under discussion. Open-ended questions were used together with probes to gain more depth and for clarification[129]. The researcher ensured that the wording of questions was clear to the participants[57].

Byers and Wilcox[128] suggested some of the advantages of the focus group interview in general and as implemented in this study were:

1. Release of inhibition by participants. It encouraged full and open expression of participantsô perceptions, experiences and practices.

2. Flexibility. A focus group interview is typically more flexible than an individual interview.
3. Handling contingencies. It explored avenues of importance, which arose other than those listed in the questionnaire.
4. Time. Eliciting responses from four to eight participants in a focus group interview, which lasted for two hours, was more time effective than interviewing the same number of participants individually (p.66).

For the focus group interviews used in this study, the researcher chose key informants (occupational therapists with more than five yearsô experience working in the field of vocational rehabilitation and/or mental health and who hold postgraduate qualifications in vocational rehabilitation and/or mental health). First preference was given to those who worked in both the fields of mental health and vocational rehabilitation. The use of occupational therapistsô with post-graduate qualifications was aimed at getting their expert perceptions and practices about work capacity evaluation given that this group has practitioners with experience in this field as well as post graduate qualifications. As such, this group could be used as experts in the field, capable of contributing very rich data.

The interview guide in Appendix 3 was developed mindful of the fact that the questions should be specific and phrased in a balanced or neutral way[58,146]. The researcher requested three senior lecturers, experts in qualitative studies to scrutinise the questions before they were used for the focus group interviews. The interview guide comprised demographic information and six open-ended questions for discussion in the focus group interview. A consent form was attached to the interview guide.

The participants who did not take part in phase one and phase two of the study was telephonically contacted to take part in the focus group discussion. The interview guide and consent form were e-mailed to those participants who agreed to take part in the focus group interviews before hand so that they could familiarise themselves with the nature of the topics or questions that were going to be discussed in the focus group interviews. Eighteen potential participants were also informed about the date, venue and time for the focus group interviews.

Two focus group interviews were held. All the participants for the focus group interviews were from Gauteng (Pretoria and Johannesburg). The researcher and the participants met at a mutually agreed venue. The first one was on the 10th May 2008 at the University of Pretoria, Occupational Therapy Department (Pretoria). Eight participants were invited and they confirmed their attendance a day prior to the focus group discussion. However, only four participants (50%) honoured the invitation, excluding the scribe.

The second focus group interview was on the 7th June 2008 at Netcare Rehabilitation Unit in Auckland Park (Johannesburg). Ten participants were invited, and seven participants (70%) attended the focus group interview excluding the scribe. The response rate for both focus group interviews was 61.1% which was a good response rate. In both focus group interviews, the participants signed the consent form and were informed of their right to withdraw from the focus group discussion at any time. Open-ended questions were used to encourage reflection and rich description of ideas and experiences, and participants were encouraged to elaborate on their answers[139] using their experiences and examples. The researcher held only two focus group interviews as data saturation was obtained.

3.5.4 Phase four: Member checking

Phase four was held on the 24th October 2009 in Johannesburg where the findings of data obtained in phase three were discussed with the participants.

Nine participants attended the member checking. The findings were shown to the participants for elaboration and confirmation as they will be shown in Chapter 4.

3.6 Inclusion criteria

3.6.1 Phase one: Descriptive questions

For the descriptive questions (Appendix 1), the researcher included all the occupational therapists that had completed their Post Graduate Diploma in Vocational Rehabilitation at the University of Pretoria and the population is relatively small. This was in an attempt to get a broader view since they were likely to be involved in vocational assessments (work capacity

evaluations) on a regular basis in their practices. The questionnaires were posted to occupational therapists practicing in South Africa. The reason for choosing occupational therapists that had completed vocational rehabilitation at post graduate level was to help the researcher develop a basis for relevant questions for other phases of this study.

3.6.2 Phase two: Close-ended questionnaire

For this questionnaire, the researcher posted the questionnaires (Appendix 2) to occupational therapists who worked in the field of vocational rehabilitation and/or mental health. Practice experience was not a key factor since the researcher wanted to confirm and find agreement with the information that was obtained in phase one. The occupational therapists were identified from the OTASA directory of occupational therapists in private practice. The questionnaire was posted to occupational therapists who practise in South Africa.

3.6.3 Phase three: Focus group interview

For the focus group interviews, the researcher included occupational therapists who worked in private practices, universities and provincial hospitals in Gauteng. The focus group interview was a homogeneous group with respect to occupational therapists with post-graduate qualifications (vocational rehabilitation and/or mental health) from any university in South Africa that offered occupational therapy as a training program. The participants had more than ten years working experience. The reason for choosing occupational therapists in Gauteng was that they were easily accessible for the researcher since he stays in Gauteng province. This was therefore a purposive sampling[129], given that the participants were selected on the fact that they have to comply with the characteristics of experienced occupational therapists. It was also a convenience sample[57,129] given that the participants were selected on the fact that they were conveniently available[129].

3.6.4 Phase four: Member checking

The participants, who took part in phase three, were the same participants who were included in phase four of the study.

3.7 Exclusion criteria

Occupational therapists who did not work in the field of mental health and/or vocational rehabilitation were excluded from participation in the entire study. Occupational therapists who work in mining hospitals and insurance companies were excluded for the focus group interview. Occupational therapists who work in the insurance companies were excluded since their job focuses on administration and case management. Those who work in mining hospitals were excluded since their practices only service mining employees who are doing the same types of jobs (working underground). Their experiences were therefore regarded as too specific for the study. Other mental conditions classified in the DSM-IV-TR (such as Major Depressive Disorder with psychotic features, substance related disorders, other psychotic disorders, anxiety disorders, chronic fatigue syndrome, schizophrenia etc.) were not discussed in this study.

3.8 Sample size

3.8.1 General aspects

It was not always possible to determine the required number of participants before conducting the research and carrying out analyses. The researcher required knowledge that addresses a broad range of topic manifestation, until data saturation[57,131]. Saturation can be achieved with a relatively small sample[57]. The sample size depends on a number of factors but generally, there is no right sample size[143]. In any case, a consensus towards the use of smaller sample size is the emerging norm as the analysis of large data sets results in the loss of potentially subtle inflections of meanings[148]. In addition, qualitative researchers mostly use a smaller number of participants[149]. The homogeneous sampling strategy was used, as its purpose was to describe the experience[149] of occupational therapists during work capacity of employees suffering from MDD.

3.8.2 Phase one: Descriptive questions

For the descriptive questions, the researcher sent the questionnaire to 60 occupational therapists who completed the Post-Graduate Diploma in Vocational Rehabilitation from the

University of Pretoria and the population is relatively small. The researcher e-mailed and or posted the open-ended questions together with a covering letter explaining the purpose of the study (refer to Appendix 1) with stamped and self-addressed envelope[58]. The total number of 60 questionnaires were posted and 40 e-mailed to the same participants. The researcher received only 28 responses. The disadvantage of mailing questionnaires is the likelihood of low response rates of 10-20%[58].

3.8.3 Phase two: Close-ended questionnaire

For the close-ended questionnaire, 50 questionnaires (Appendix 2) were posted and e-mailed to the participants who were registered with OTASA and were found in the OTASA directory of occupational therapists in mental health and vocational rehabilitation. The OTASA office assisted with follow up e-mailing of these close-ended questionnaires. The researcher received 29 responses, which was a good response rate of more than 50% with regard to e-mailed questionnaires[57].

3.8.4 Phase three: Focus group interview

There was a need for homogeneity of participants, which is known as ñsegmentationò[136]. Segmentation allows the participants discussion to be easy[136]. Each focus group in this study was envisaged to have six to eight participants (experienced occupational therapists) per group. It was estimated to have at least four focus group interview sessions until saturation of data occurs (when the information collected does not change due to lack of new input)[134,136,143,147]. The researcher wanted to have a bigger sample size of 24 to 32 participants in phase three, and ignored the fact that saturation could be achieved with a small sample size as stated by Polit and Beck[57]. The same small sample size applied in this research study.

In the focus group interviews held, however, there were only four in Group one and seven in Group two. The total number of participants who took part in the focus group interviews in this research study was 11. A smaller group of four to seven participants ensured that each participant (member of the focus group) had a fair chance to give his or her input, even

though it was not intentionally planned, it became beneficial. The number worked well for the study.

The researcher realised that the information he was receiving in the focus group interview was the same as that received in phase one and that which was confirmed in phase two of the study and decided not to continue with a third or fourth session.

The interview style was non-directive[143]. The method was useful for exploring participantsô knowledge and experience, and for examining the why and how of doing things[150].

3.8.5 Phase four: Member checking

Member checking took place at Johannesburg (Netcare Rehabilitation Unit). A total of nine participants attended the member checking, excluding the scribe. Two participants did not manage to attend the feedback session during member checking. The researcher discussed the findings with the participants who had attended focus group interviews one and two.

The total sample size for this research study was 68 participants (28 participants in phase one, 29 participants in phase two, 11 participants in phase three and nine participants in phase four). The nine participants in phase four are the same ones who took part in phase three and the scribe.

3.9 Sampling technique

Purposive sampling was used since it required the researcher to strategically judge and select knowledgeable participants with regard to the research area and who would be able to articulate and explain experiences to the researcher[65,129,135,147]. In purposive sampling, the size of the sample is determined by informational consideration. Although the process tends to be non-random, in-order to minimise participant bias, the researcher randomly selected the participants[147] as a small sample was used. The logic and power of purposive sampling lies in selecting information-rich cases for in-depth study. Information rich cases are those from whom one can learn a great deal about issues of central importance to the purpose of the

inquiry[127,134]. Purposive sampling is often used when the researcher requires a sample of experts[57]. The goal of purposive sampling is to add new perspectives about the phenomenon being studied[147].

The shortcoming of purposive sampling was that the judgement of the researcher was obviously too prominent a factor in this type of sample. The researcher assumed that the experts with experience in the field of vocational rehabilitation and mental health would be the best placed and most relevant participants for this study. Regarding purposive sampling, however, the researcher purposely seeks typical and divergent data[129,143,151]. This may be supplemented with new participants through snowballing[57]. It was also a convenience sample[57,129] given that the participants in phase three and four were selected on the fact that they were conveniently available[129] in Gauteng.

3.10 Data collection techniques

The data collected in qualitative research was thick, rich and deep, which often over-rode the preconceived attitudes of the researcher[150] since it brought clarity to help the researcher understand the participantsô experience. Descriptive phenomenology[57] was used in the form of in-depth interviews (focus group interviews) with participants who had experienced the phenomenon of interest, in this case performing WCE on employees suffering from MDD. When a description and the focus group interview are used together, the description usually comes first and in this study the description was used as a basis for further elaboration during the focus group interviews[137].

3.11 Measuring Instrument or tools

The following tools were used to assist the researcher in data collection:

3.11.1 Phase one: Descriptive questions

Qualitative researchers use flexible methods of gathering self-report data[57]. A typical descriptive study is merely intended to describe a phenomenon[64]. In this study, the researcher was searching for the practices and perceptions of occupational therapists during WCE.

Data needed to be collected through straightforward descriptions and the questions needed to be generally broad and open-ended[137], so that the participants could have sufficient opportunity to express their viewpoint extensively[137]. What was sought was a concrete, detailed description of the participantsô experiences and actions, as faithfully as possible[137]. The researcher used the aim and objectives of the study to formulate the questions. The questions were analysed by the research supervisor and changes were made after feedback from the latter. The questions that were included in open-ended descriptive questions appear in Appendix 1.

3.11.2 Phase two: Close-ended questionnaire

The close-ended questionnaire is another data collection method, which was used in phase two to confirm some of the information obtained in phase one. From the responses in phase one, the researcher determined themes that needed confirmation by ñyes,ò ñno,ò ñagreeò or ñdisagreeò. The information that the researcher chose for clarification, did not need any discussion or clarification, except agreement. The questionnaire was examined by a senior lecturer in the Department of Occupational Therapy, another lecturer from the Ethics Committee of the University of Pretoria and the research supervisor. After feedback was given, changes in the formulation of questions were made. The question areas that were covered in the close-ended questionnaire appear in Appendix 2.

3.11.3 Phase three: Focus group interview

The following methods of data collection were used in phase three of the study:

(i) Tape recorder

It is not possible to conduct a focus group interview without a tape recorder[57,113,129,131,148,149]. The tape recorder was used during the focus group interview to record the sessions, since in a qualitative study, data analysis must be systematic, sequential, verifiable and continuous[60].

Permission was obtained from the participants to use the tape recorder prior to the commencement of the focus group interviews and the reason for such was explained to the participants. All the participants agreed that the researcher could use a tape recorder.

(ii) Field notes

Field notes contain the description of what has been observed. The scribe captured all the observed information using field notes. The notes were dated, and they recorded basic information such as where the focus group interview took place, which participants were present, the structure of the physical setting, the social interaction that took place during each focus group interview and the topics discussed. At the end of the focus group interviews, the scribe and the researcher evaluated the focus group interview by writing their own feelings about the whole session, reflections about their personal experience and the significance of what had been observed throughout the session. Field notes included the observerôs insights, interpretations, beginning analyses and working hypotheses[113,129,131,134].

(iii) Focus group interview guide

The research technique used was the focus group interview following an interview guide. Focus group interview is a research technique that is used to generate the research data through group interaction on a topic determined by the researcher[65,150]. In this case, the researcher determined and prepared possible topics/open-ended questions[143] for the group so that the researcher could learn of the participantsô views, perceptions and practices while determining work capacity. The question areas that were covered in the focus group interview guide[57] are included in Appendix 3. The open-ended questions in the interview guide were

determined by the researcher from the responses received and analysed in phase one of the descriptive questions. The interview guide was e-mailed to the participants prior to the focus group interviews. The researcher (moderator) facilitated each focus group interview.

(iv) The scribe

The assistant facilitator worked as a scribe to take detailed field notes, perform participatory observation, and to change the tape recorder cassettes. There was no need for the second assistant (as stated in the protocol) since there was few participants during the focus group interview. The researcher selected a scribe who had worked in the field of mental health for more than ten years so that she could completely follow the discussion due to her relevant experience and knowledge of terminologies and aspects linked to the research area. Since there were few participants, the scribe was allowed to add value, make comments and contribute to the discussions during the focus group interview. This did not have an influence on trustworthiness as the data was recorded and transcribed verbatim by the researcher and coded by independent coder.

3.11.4 Phase four: Member checking

The tape recorder, field notes and scribe were used as discussed in phase three.

3.12 Data Analyses

In this study, data analysis was an on-going process that occurred as data was collected in what is called sequential mixed analysis[127].

3.12.1 Phase one: Descriptive questions

In this phase, analysis was conducted concurrently with data collection. This means, as analysis occurred, the researcher developed further questions that guided on-going data

collection in phase 2 (Appendix 2) and phase 3 (Appendix 3). The researcher analysed the data, proposed new questions using inductive and deductive procedures[113].

(i) Phase one and phase three: Phenomenological analysis

Descriptive phenomenological studies often involve the following four steps: bracketing, intuiting, analyzing and describing[57].

Step 1:

The first step in phenomenological analysis is epoche (or bracketing). According to Patton[134] (2002) and Creswell[61] (2007), epoche is the process that the researcher engages in to set aside his/her experiences, prejudices, viewpoints or assumptions regarding the phenomenon under investigation and take a fresh perspective towards the phenomenon under investigation. Epoche is an on-going analytical process rather than a single fixed event[134]. The interpretive phenomenological analysis (phenomenography)[61,152] has tended to focus on the exploration of participantsô experiences, understandings, perceptions and views. The analysis requires close interaction between analyst and text[143]. In this research study, the researchersô experience, viewpoint, assumptions, or prejudices regarding the phenomenon under investigation were set aside. The researcher was actively involved with the collection and at times, analysis of data as it was received.

Step 2:

The researcher bracketed himself out to identify the data in pure form, uncontaminated by extraneous intrusions as advised by Patton[134]. The researcher inspected the recurring features of the phenomenon being studied and obtained the participants interpretation of phrases. Once data was bracketed, all the aspects of the data were treated with equal value. The researcher highlighted significant statements, sentences or quotes that provided an understanding of how the participants experienced the phenomenon in a process called ñhorizonalizationò[61]. The researcher then undertook a delimitation process whereby irrelevant, repetitive or overlapping data were eliminated.

Step 3 (final step):

The researcher coded the themes that emerged throughout the study through the integration of composite textual and composite structural description[61].

(ii) Phase one: Content analysis

In phase one, the data were analysed using content analysis and ranking the responses in order of preferences and percentages[146]. Averages and percentages described the data in a more tidy form[146]. For the open-ended questions, the answers were analysed into categories, making check marks for repeated responses and translating the material into manageable and comprehensible form[146].

After the descriptive analysis, the common responses from the descriptive questions were categorised into themes to be used in the focus group interview. Those themes were developed from the descriptive analysis (Appendix 1) and were attached to Appendix 3 of the study for use in the focus group interview.

3.12.2 Phase two: Statistical analysis

Simple statistics (percentages) were used to describe the data. The aim was to convert and condense the data into organised, visual representation, in a variety of ways to facilitate reading for meaning[64]. The following statistical measures were used following Brink, van der Walt and van Rensburg[64].

(i) Phase two: Frequency distribution

A numerical way of summarising the variables is by means of frequency distribution[129] or frequency tables[153]. The idea of the frequency distribution is to explain the number of cases in each category[153]. In such a distribution the different response categories of a variable are shown together with the frequency (number) of respondents, and usually the frequency is

expressed as a percentage of the sample size, in each of the different categories[129]. Frequencies are obtained by simply counting the occurrence of scores represented in the data. A frequency distribution is a systematic arrangement of the lowest to the highest score linked with the number of times the score occurs[64,153]. In validating themes, the researcher used quasi statistics, a tabulation of the frequency with which certain themes were supported by the data[57].

Very often, a researcher needs to compute percentages, which tell us the proportion of cases contained within each frequency, i.e. relative frequency[153]. In this study, the scores were grouped together. The level of measurement that was used was nominal data where:

Table 3.1: Nominal data

Symbol	Representation
N	The number of cases (sample size)
N	The number of cases in population (population size)
F	Frequency of cases
rf%	Relative frequency or percentages

The subject descriptors were displayed using bar charts. The responses to the questionnaire in phase one and two were divided into categories of respondents. Simple descriptive statistics are used after the data have been summarised into frequency distributions, and it is often useful to make comparisons concerning the relative frequencies of scores falling into specific categories[64].

3.12.3 Phase three: Focus group interview

(i) Organising data

The researcher ensured that all the data were properly labelled (dates, places, identifying information and number of participants) and the field notes were completed along with the audio recordings for each session.

(ii) Content analysis and inductive analysis

Dividing the data into segments was carried out using the content analysis procedure[113]. This is a process for discovering and/or formulating appropriate categories for subsequent quantification[127, 128]. Content analysis is used to analyse qualitative responses to open-ended questions of focus group interviews[129]. It looks for the frequency of certain types of statements and the incidence of general categories and groups them according to their similarities[127].

The transcripts were written in a question-by-question format to capture what the group had to say on each question[129]. The audio tapes were transcribed verbatim - i.e. rewritten word for word[136] as a standard procedure and the transcribed responses were read a number of times[148] for complementarity with the emerging themes. The language used was English since it was a common language to the participants some of whom were not first language speakers of English but were more than competent in the language. Transcribing took one month, as the researcher had to transcribe the whole discussion including the researcherôs questions.

i. Inductive analysis is used to discover themes and categories or open coding is applied[113,131,134,143]. Categories were then compared to each other to ensure that all categories were extremely distinct and yet consistent[57,136]. The researcher clustered together categories that were alike[57,113]. It was an inductive process, which looked for similarities, and differences in text[129].

ii. Thematic analysis was carried out to compare and contrast similarities across the data[57]. The researcher searched the texts to try to identify recurring themes or patterns[57,143] along with supporting quotations from the participants[139]. The analysis was a detailed approach as the researcher analysed the transcribed data line-by-line[57]. Themes were then identified. Peterson and Higgs[139] describes themes ñas a means of understanding or clarifying the notion being studiedò (p.351). Thematic analysis of phases one and three yielded extremely interesting information, categories and subcategories[129].

iii. These themes were divided into three groups as transcription (what the participants had said), manifested content (the objective of the study), and latent content and the relation to literature or theory (interpretation by the researcher)[65,136,147]. The researcher took care in the production of the list of themes to ensure that each theme was actually represented in the transcripts[143]. The transcripts were analysed and crosschecked to ensure the interpretation of each conception[152]. This cross checking led to clearer and more precise formulation of concepts[152].

iv. The researcher used member checking (participantsô feedback on preliminary interpretations)[143] of the data to determine the accuracy of the findings; whether these participants felt that they were accurate and the researcher had understood them well.

3.12.4 Phase four: Member checking

The content analysis was used as discussed in phase three.

3.13 Measures to ensure trustworthiness

Trustworthiness involves examining aspects of truth-value, rigor, integrity, applicability, consistency and neutrality in research[57,127]. For the descriptive questions, the researcher focused on content validity to ensure that he measured the knowledge of the participants.

Lincoln and Cuba (1994) cited by Polit and Beck[57] suggest five criteria for developing the trustworthiness of a qualitative enquiry: credibility, dependability, confirmability, transferability and later added a fifth criterion, authenticity. For this study, the researcher used the criterion of strategies to ensure trustworthiness of the findings[57,64,129].

3.13.1 Credibility of data

Credibility refers to confidence in the truth-value or believability of the results[57,139]. The following processes and research aspects were employed to achieve credibility.

a) **Triangulation:** According to Denzin and Lincoln[63] triangulation is the simultaneous display of multiple realities with less risk of bias. The following forms of triangulation were applied:

i. Methodological triangulation was done through using the qualitative (descriptive questions and focus group interviews) and quantitative (close-ended questionnaire) approach. The researcher used different methods of data collection in different phases to ensure consistency of the findings.

ii. The researcher used descriptive questions (open-ended questions), questionnaire (close-ended questions), tape recorder, focus group interview guide, observations and the field notes to triangulate. These assisted with cross data validity checks. The researcher also arranged a feedback session with the participants who took part in the focus group interview to assess if they agreed with the findings and the conclusions developed by the researcher (member checking). The most crucial technique for establishing credibility is through member checks[57,127,133,136,154]. A formal member check regarding the accuracy of the findings was the most significant method to address credibility in this study[136].

iii. Space triangulation whereby the researcher collected data on work capacity of employees suffering from MDD in multiple sites (Pretoria and Johannesburg) to test for cross-site consistency[57] was also done. The researcher used different participants at different sites to ensure the credibility of data.

iv. Person triangulation involved collecting data from different occupational therapists who work in vocational rehabilitation, mental health or both, and with different years of experience[57]. This helped the researcher to understand the participantôs different approaches at different practices.

v. The researcher used multiple participants to provide accounts from different perspectives about an experience. Multiple participants served as a kind of triangulation on the experience, locating its core meaning by approaching it

through different accounts[149]. The researcher used different participants for the descriptive questions, close-ended questionnaire and focus group interviews. The use of multiple participants served to deepen the understanding of the investigated experience[129,149] of the occupational therapists.

vi. During the discussion of findings, the researcher used theory triangulation to compare the findings to the theory and literature reviews.

b) **Member checking:** Trustworthiness is defined as confidence that the information is accurate and reflects a particular reality[139]. The researcher used member checking, on-going supervisor critique and validation of the findings. During member checking, the participants were open to disagree with certain information and contributed with amendments and clarifications of terms to the researcher.

c) **Rigour:** The credibility of the research was enhanced by the rigour of its conduct[139] since there was a depth of dialogue between the researcher, participants and the use of literature.

d) **Peer examination:** To confirm categories and themes, the researcher used an external auditor to check the entire project, including data analysis. Validity checks in this context were not meant to prescribe to a singular true account but to ensure the credibility of the final account[143]. Credibility was ensured by the adoption of measures such as having the data scrutinised by others[143] and discussing their findings with the researcher.

e) **Credibility of the researcher:** The researcher submitted his curriculum vitae to the Post-Graduate and Research Committee of the Occupational Therapy Department of the University of Pretoria for their perusal, consideration and approval. The researcher has been practicing in the field of vocational rehabilitation and mental health for 16 years. The researcher is the part time lecturer in Post Graduate Diploma in Vocational Rehabilitation at University of Pretoria, Department of Occupational Therapy.

3.13.2 Dependability of data

Dependability refers ñto the stability (reliability) of data over time and over conditionsò[57](p.492). The researcher ensured that the study methodology was documented accurately and in detail. An external auditor, a clinical psychologist audited the data from the focus group as discussed earlier and the findings from phase one and two were discussed with the research supervisor. Since there was agreement on data analysis, the findings were acceptable. This process of documentation allows for the dependability of the study as it can be replicated if needed.

3.13.3 Confirmability of data

Confirmability refers to ñobjectivity, that is, the potential for congruence between two or more independent people about the accuracy, relevance, or meaning of a phenomenonò[57] (p.492). In an effort to achieve confirmability, the research took the following steps:

a) **External auditor:** An external auditor (independent coder), a clinical psychologist by profession independently coded the transcripts[129,147,152]. This crystallised reality was credible as there were similar themes, thus add to the trustworthiness of the study[129]. The researcher documented the process of checking and rechecking of the data throughout the study as the research had four phases of data collection.

b) **Bracketing:** To reduce contamination that the researcher could bring to the study, he used scribes to take field notes during the focus group interviews so that the scribes and the researcher could reflect on their observations and themes at the end of each focus group interview. Being reflexive (bracketing one-self), allowed the researcher to be less subjective when analysing the data[127].

3.13.4 Transferability of data

Transferability refers ñto the extent to which qualitative findings can be transferred to other settings or groups or samplesò[57](p.492). The following brief discussion gives an account of, and reasons for what the researcher did.

a) Phenomenological reduction meant that the researcher tried to bracket all the past knowledge or theories about the phenomenon being researched[137,140]. The researcherôs response was to bracket himself and to stick to what was theoretically sound and justifiable[140]. The researcher managed to bracket himself throughout the study in order to clearly get the views, perceptions and practices of occupational therapistsô doing work capacity evaluations.
b) The researcher gave details of the steps/phases followed during the research should there be a need to replicate the study in another context or area.

3.13.5 Authenticity of data

Authenticity refers to ñthe extent to which researcher fairly and faithfully shows a range of different realities. Authenticity emerges in a report when it conveys the feeling tone of participantsô lives as they are livedò[57] (p.493).

a) Authenticity rather than reliability is often an issue in qualitative research. The aim in this research was to gather an authentic understanding of occupational therapistsô experiences and the researcher was of the opinion that open-ended questions used in the descriptive questions and focus group were the most effective routes towards this end[139].

3.14 Validity and Reliability

3.14.1 Validity

Validity refers to the degree to which an instrument measures what it is intended to measure[57,113,127,129] to give the true findings. The researcher ensured validity and reliability during the formulation of questionnaires as follows:

a) **Internal validity:** The researcher ensured internal validity by having the close-ended questionnaire in phase two to be reviewed by experts - senior lecturers from the Department of Occupational Therapy, Ethics Committee and Research Committee of the University of Pretoria and the research supervisor - to ensure that the questionnaire was adequate for measuring what it is meant to measure. This is an example of ensuring internal validity[57,113,127,129]. The researcher also used triangulation on the methods of data collection and data analysis, in order to determine discrepancies in the findings.

b) **External validity:** The researcher used rich, thick descriptions of the participants and contexts to facilitate external validity.

c) **Face validity:** The questions on the researchersô questionnaires were relevant, clear and unambiguous. They were scrutinised by experts in the field (refer to internal validity above)

d) **Construct validity:** Construct validity was obtained by use of multiple sources of evidence. Triangulation was employed to ensure that the data methods used to obtain the data were reliable and that the conclusion generated by the researcher was valid.

3.14.2 Reliability

Synonymous terms are reproducibility and reliability[127]. Reliability refers to the accuracy and consistency of information obtained in the study[57,113,127,129]. The researcher ensured reliability of data by using data triangulation.

3.15 Conclusion

The use of the mixed methods was found to be an effective research method due to its complementarity. Through the phases, the researcher used different questionnaires (open-ended and close-ended questions) as means of data collection. Content analysis was used during phase one and phase three of data analysis. The frequency distributions were used to analyse phase two. Triangulation, member check, and external auditor were used to ensure the trustworthiness and credibility of the study.

3.16 Summary

This chapter discussed research design, research strategies, selection of participants and data collection methods. Also elaborated on were data analysis and the measures that were used to ensure the credibility and transferability of the study. The next chapter addresses analysis of findings.

CHAPTER 4

RESEARCH FINDINGS AND DISCUSSION

4.1 Introduction

In Chapter 3, the research methods, design and methodology were explained in depth. In this chapter, the findings of the data analysis are given and discussed according to the research aim and objectives. Frequency distribution, percentages, content analysis and inductive analysis are used to present and discuss the findings. The chapter discusses the findings, their interpretations and arguments related to the identified themes in the study. Findings are further triangulated by comparing them to current relevant literature.

The demographic data of the study participants who completed the descriptive questions in phase one (open-ended questions), close-ended questionnaires in phase two, focus group interviews in phase three and member checking in phase four are presented according to the participantsô gender, age group, areas of practice, years of experience, place of work, post-graduate qualifications, universities of graduation and participantôs province of work.

The research participantsô responses from the descriptive questions in phase one, which formed the foundation for confirmation of topics used in the close-ended questionnaire in phase two, will be illustrated using tables. The findings of phase two will be illustrated through figures. The findings of phase three (focus group interview) will be illustrated verbatim. The use of themes, subthemes, categories and subcategories that were extrapolated from the focus group interviews in phase three and confirmed during member checking in phase four will be illustrated by use of tables and diagrams. Such representations of data are an effort to streamline the findings with the research aim and objectives of the study.

4.2 Response rate

The response rate of the participants in the study are illustrated in Table 4.1 as follows:

Table 4.1: Response rate of participants

Phases	Number of questionnaires sent out	Number returned	Response rate	Rating
Phase one	60	28	46.6%	Poor
Phase two	50	29	58%	Good
Phases	**Number of invited participants**	**Number of attendees**	**Response rate**	**Rating**
Phase three	18*	11*	61.1%	Good
Phase four	11*	9*	81.8%	Good
Total	128	68	53.1%	Good

*the same participants

Sixty of the descriptive questionnaires in phase one were distributed through the post to the participants. Twenty questionnaires were emailed to the same participants (the ones whose email addresses were accessible). Mailed out questionnaires had a lower response rate of 46.6%, which concurs with the observation by Buckingham and Saunders[58] reported that ñmailed out questionnaires have the likelihood of low response of 10-20%ò. The response rate for the emailed questionnaires was 58% and matched the remark by Polit and Beck[57] that there is an envisaged good response rate of more than 50% with e-mailed questionnaires. As the data collection continued, the response rate continued to improve in phase two, three and four to above 50%.

4.3 Demographic data

The participants in this study were occupational therapists registered with the Health Professions Council of South Africa. It must be noted that different participants were used in phase one and two whereas those who were in phase four, expecting two dropouts, were the same participants who took part in phase three. The profiles of the participants will be discussed as follows:

4.3.1 Participants' gender

Most of the research participants in this study were female as illustrated in Figure I.

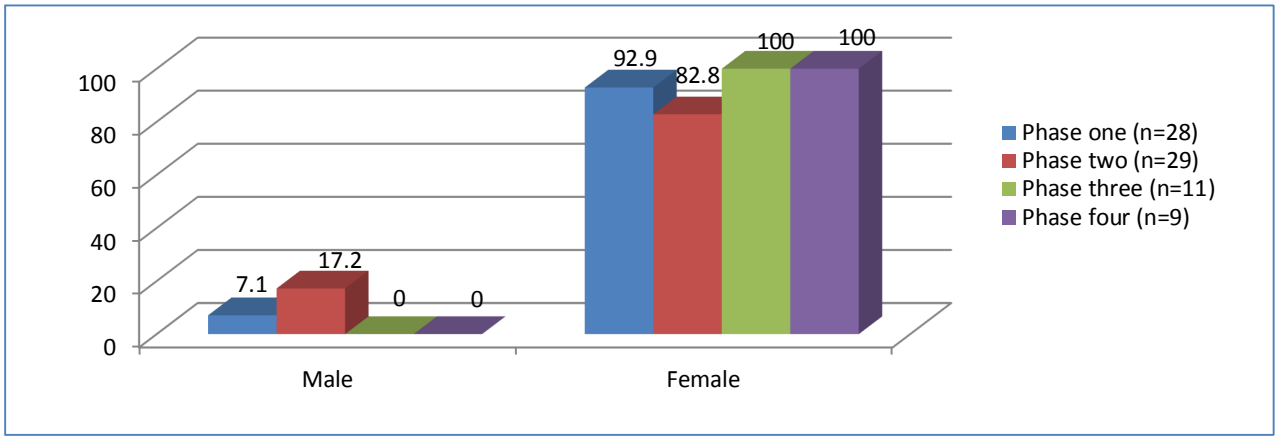

Figure I: Participants' gender

During phase one, two (7.1%) of the participants were male and 26 (92.9%) were female. For the questionnaire in phase two, five (17.2%) of the participants were male and 24 (82.8%) were female. The male response in phase one and two was fair considering the fact that the occupational therapy profession in South Africa is still female dominated.

Regarding the occupational therapists in the field of vocational rehabilitation and mental health in phases three and four, it was noted that all of the participants who had extensive experience in the two fields were females.

The total number of participants who took part in the whole study was 68 (excluding the same participants in phase three who attended member checking) with seven (10.3%) males and 61 (89.7%) females. According to the total number of active registrations by gender as at 19 September 2011 from the Health Professions Council of South Africa (HPCSA), they were 3,664 registered occupational therapists consisting of 163 (4.5%) males and 3,501 (95.5%) females.

4.3.2 Age group

Eighteen (63.6%) participants who completed the initial descriptive questions in phase one, which laid the foundation for this study were between 31 and 35 years of age. During phase two, 12 (41.1%) participants fell in the age group 36 to 40 years. During phase three of the study, four (36.4%) participants fell in the age group 36 to 40 years, three (27.3%)

participants fell in the age group 41 to 45 years and two (18,2%) participants in the age group 46 to 50 years. The findings of the participantsô age groups are illustrated in Figure II.

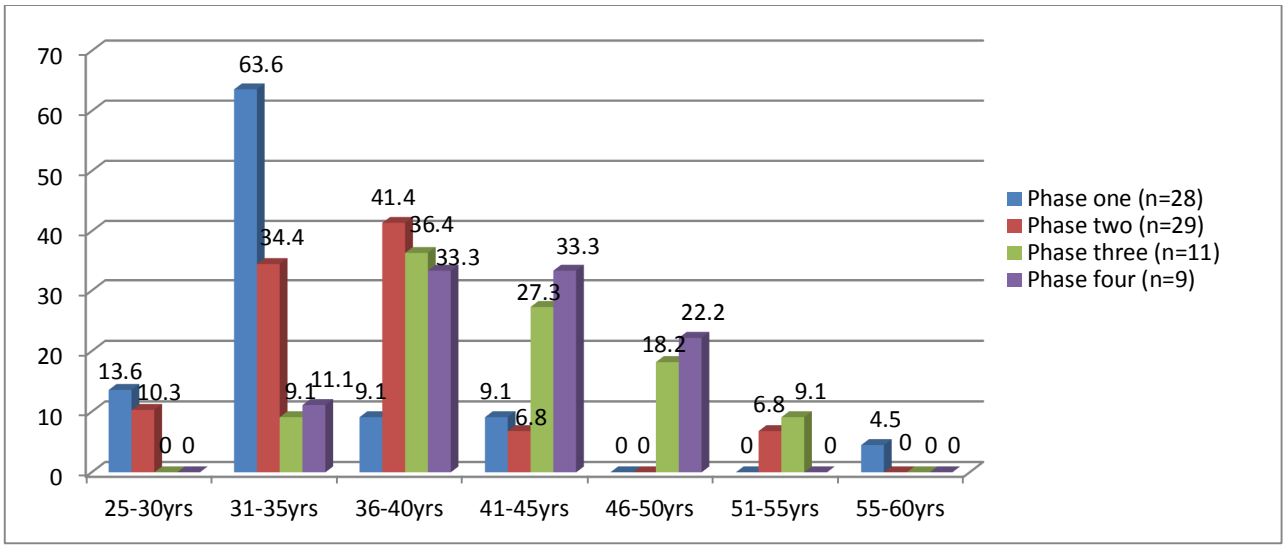

Figure II: Age group of participants

4.3.3 Areas of practice

The diversity of the participantsô areas of practice is illustrated in Figure III.

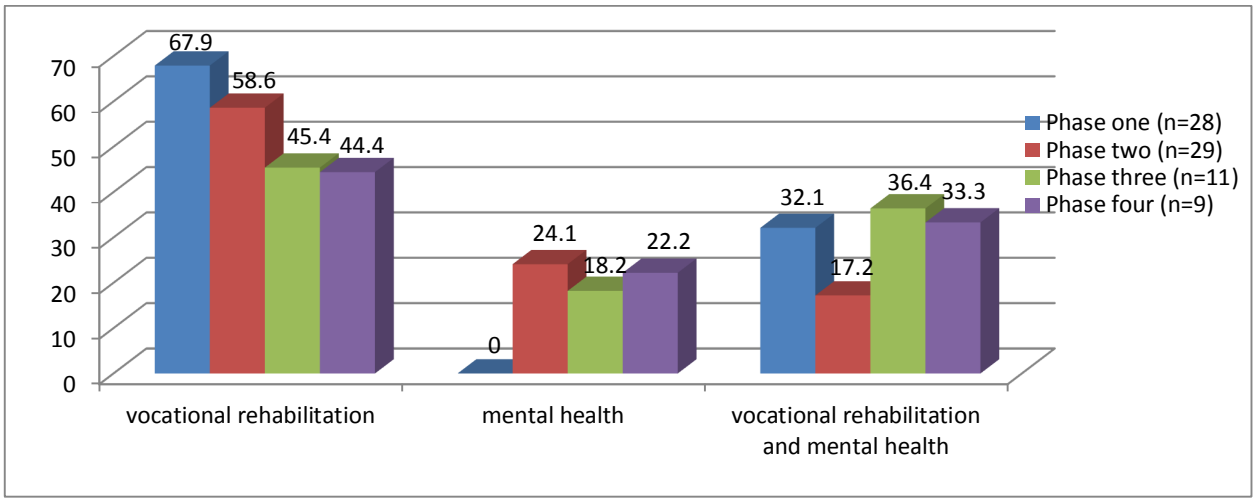

Figure III: Participants' areas of practice

The research participants of this study were practicing in the fields of vocational rehabilitation and mental health. For the descriptive questions in phase one, 19 (68.2%) participants were practicing in the field of vocational rehabilitation. None of the participants

were practicing in the field of mental health only. There were nine (32.1%) participants practising in the field of vocational rehabilitation and mental health.

In phase two (close-ended questionnaire), 17 (58.6%) of the participants practised in vocational rehabilitation, 7 (24.1%) in mental health and five (17.2%) were occupational therapists working in more than one area of occupational therapy, including mental health and vocational rehabilitation.

For the focus group interview in phase three, five (45.4%) of the participants practiced in vocational rehabilitation, two (18.2%) in mental health and four (36.4%) in mental health and vocational rehabilitation. In phase four, four of the participants (44.4%) practised in vocational rehabilitation two (22.2%) participants in mental health and three (33.3%) participants in mental health and vocational rehabilitation. The majority of participants in this study were practising in the field of vocational rehabilitation. They were 41 (60.3%) out of 68 participants in vocational rehabilitation, nine (13.2%) out of 68 participants in mental health and 18 (26.5%) out of 68 participants in vocational rehabilitation and mental health. The researcher used participants in the fields.

4.3.4 Years of experience

The participantsô years of experience from the date of undergraduate qualification varied as illustrated in Figure IV. The majority of participants 13 (45.4%) who took part in phase one of the study, had work experience of between 6 and 10 years. This was followed by six (22.7%) participants who had work experience of between 11 and 15 years. There were no participants who had work experience of between 16 and 20 years or between 26 and 30 years. There was one (4.5%) participant who had work experience of between 31 and 40 years practising as an occupational therapist in mental health.

With reference to those who took part in phase two, nine (31%) and phase three, four (36.4%) had work experience of between 11 and 15 years. Eight (27.5%) participants had work experience of between 6 and 10 years and two (6.8%) of the participants had worked between 31 and 40 years.

In phase three, three (27.2%) of the participants had work experience of between 21 and 25 years in the field of vocational rehabilitation and two (18.2%) had between 26 and 30 years experience. For the focus group interview, the participantsô experience in the field of vocational rehabilitation ranged between 11 and 30 years. In phase four, the participantsô experience was between 11 and 40 years.

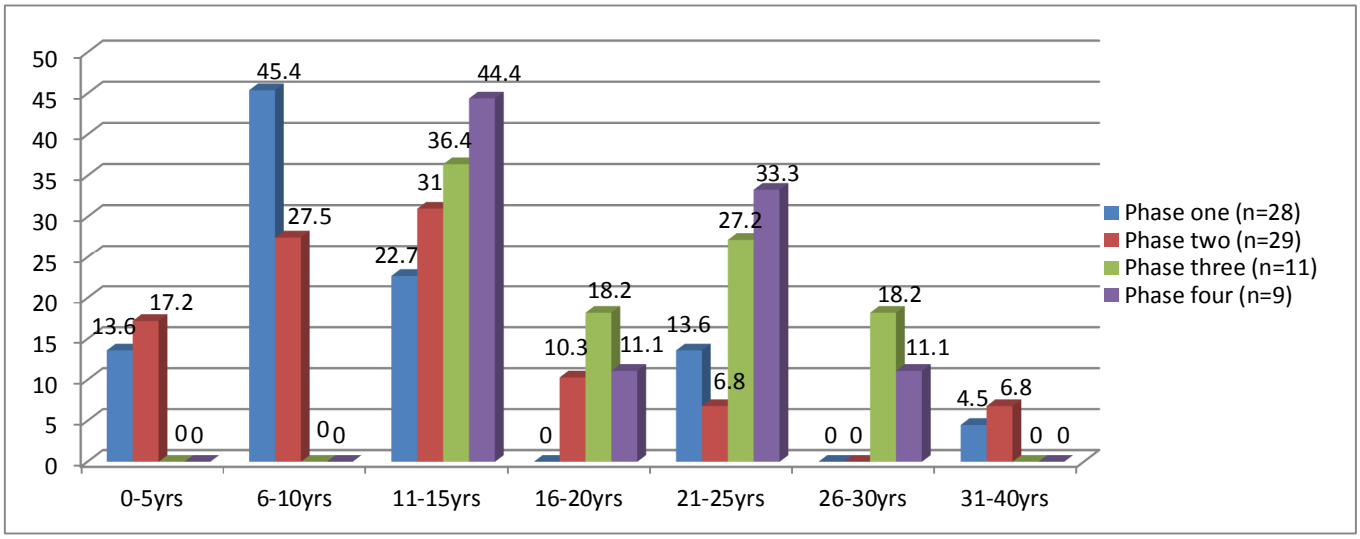

Figure IV: Participants' years of experience

Overall the participantsô experience ranged between 6 and 30 years.

4.3.5 Place of work

This subheading profiles participants according to where they worked at the time of conducting this study as illustrated in Figure V.

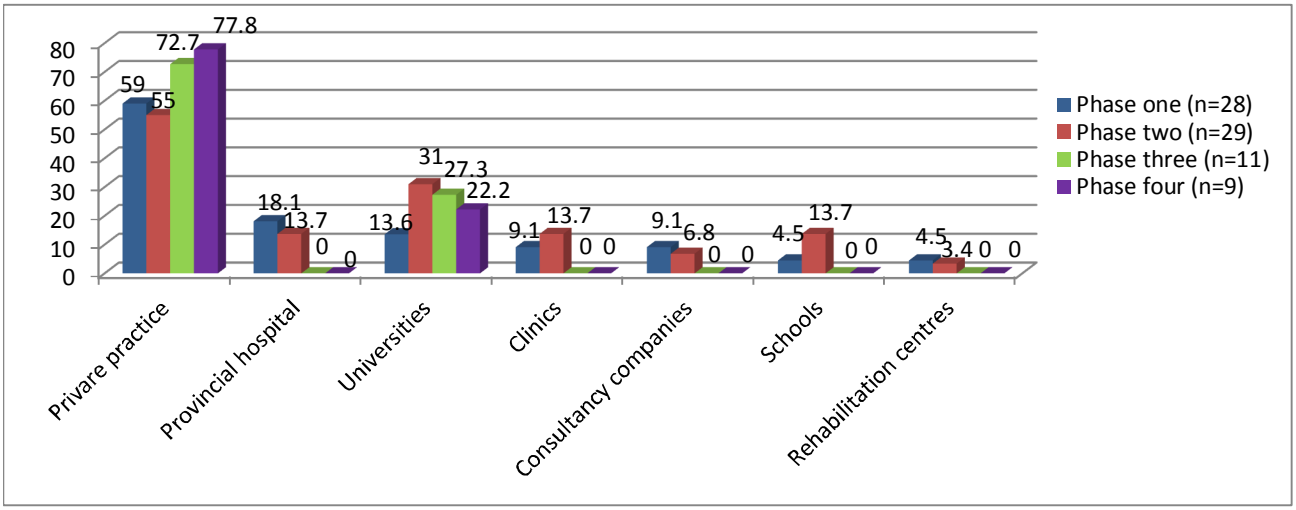

Figure V: Participants' work places

There were 17 (59%) self-employed participants in private practice in phase one, 16 (55%) in phase two and eight (72.7%) in phase three. Findings indicated that most of the occupational therapists who practise in the field of vocational rehabilitation and mental health are self-employed in private practices where most WCEs are done. The second highest group were the academics working as occupational therapy lecturers at various South African universities.

4.3.6 Post graduate qualifications

Of the participants who took part in phase one, 17 (59.1%) obtained a Post Graduate Diploma in Vocational Rehabilitation offered by the University of Pretoria. In phase three, five (45.5%) of the participants had Masters Degrees in Occupational Therapy and four (36.4%) had completed their Post Graduate Diplomas in Vocational Rehabilitation. In phase four, four (44.4%) had Masters degrees in occupational therapy and four (44.4%) had Post Graduate Diplomaôs in Vocational Rehabilitation.

Thus, most of the participants in this study had high qualifications and a wealth of experience. These details are indicated in Figure VI.

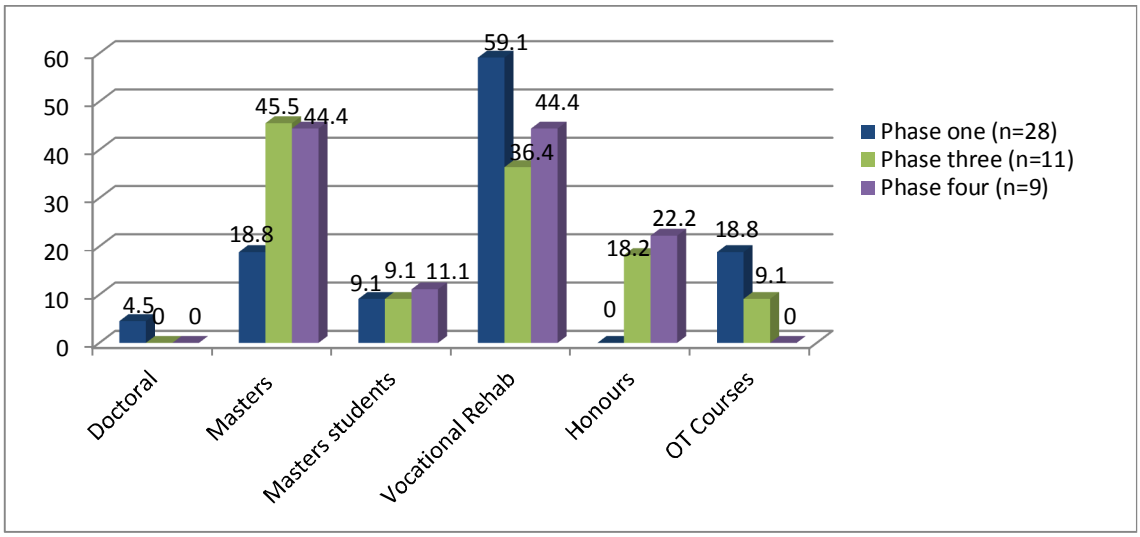

Figure VI: Participants' post graduate qualifications

In phase two, the researcher did not enquire about the participantsô specific post-graduate qualifications. Suffice to say that 21 (72%) of the participants in phase two had post-graduate qualifications in occupational Therapy and eight (28%) had only undergraduate qualifications in Occupational Therapy. Figure VII illustrates these findings.

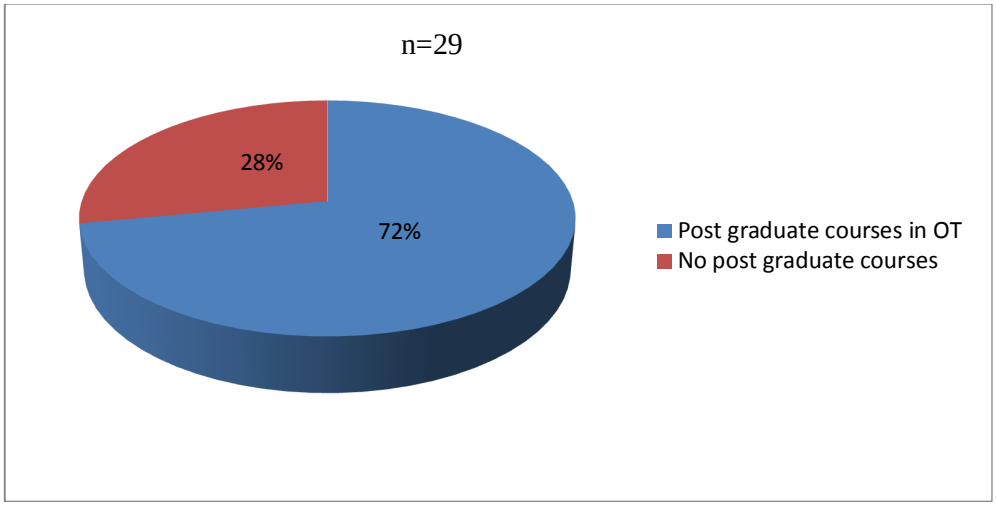

Figure VII: Participants' post-graduate qualifications in phase two

4.3.7 Undergraduate qualifications

The research participants obtained their undergraduate qualifications at six of the eight universities offering occupational therapy training in South Africa. The researcher sent the descriptive questions in phase one to occupational therapists who graduated from all of these universities in South Africa. It was noted that most of the nine (31.8%) participants who took part in phase one were from the University of Limpopo ï Medunsa campus (Medical University of South Africa), followed by six (22.7%) from University of the Witwatersrand. During phase two, the researcher did not enquire after the university where the undergraduate qualification had been obtained.

During the focus group interview in phase three, it was noted that three (27.27%) of the participants were graduates from University of Limpopo - Medunsa campus and the rest from other universities such as University of the Witwatersrand, University of the Free State, University of Pretoria and University of Stellenbosch ï all with two participants each, representing 18.18% of this sample.

During phase four, there were equal numbers of two participants (22.2%) each from the University of Limpopo (Medunsa campus), Witwatersrand, Stellenbosch and Pretoria. Only one (11.1%) participant was from the University of Free State.

Universities from which the research participants obtained their undergraduate qualifications are shown in Figure VIII.

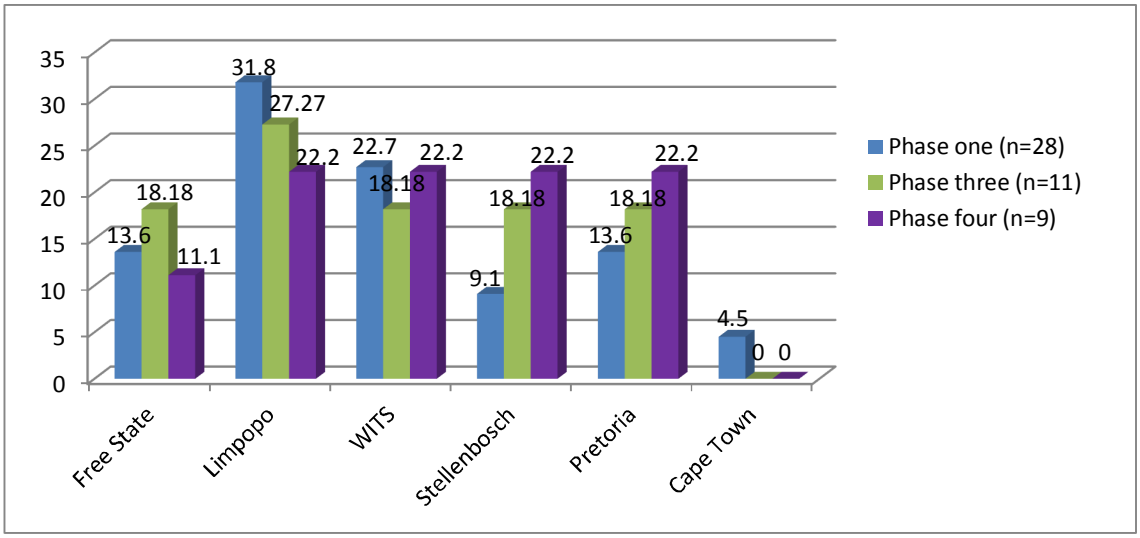

Figure VIII: Universities of undergraduate qualification

4.3.8 Participants' province of work

Most of the participants in this study were from Gauteng province, 20 (72.7%) in phase one, 21 (73%) in phase two, 11 (100%) in phase three and nine (100%) in phase four. Most of the participants in this study are from Gauteng. The details are illustrated in Figure IX.

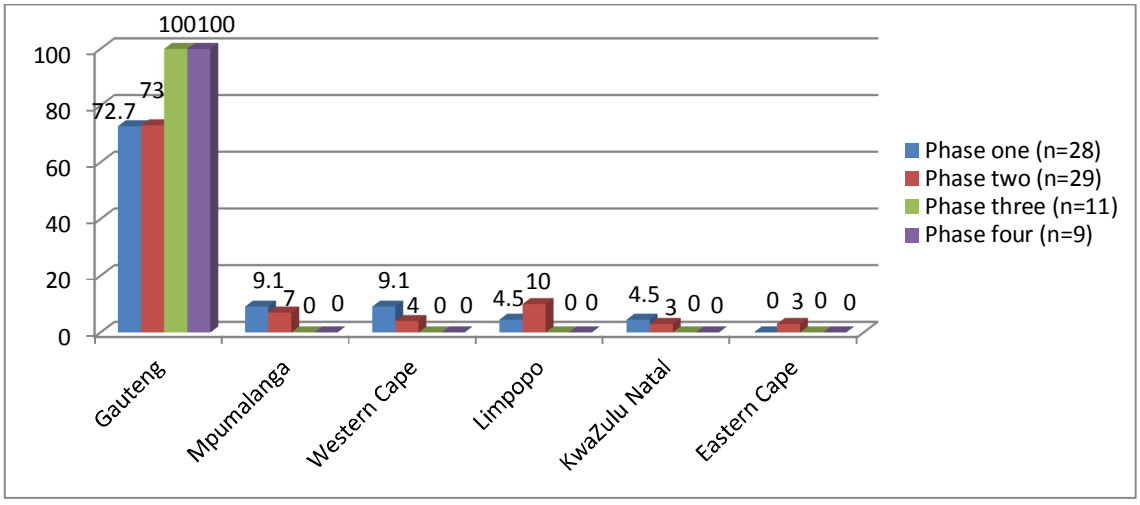

Figure IX: Participants' province of work

4.3.9 Conclusion on demographic information

The strengths of this demographic data was that the researcher managed to recruit participants who practices in the field of vocational rehabiltion and mental health as shown in Figure III. The experience of the participants in phase one and two ranged between five to 40 years and 11 to 30 years in phase three and four. Majority of the participants are practicing in private practice and universities in all the phases. All the participants in all the phases had post-graduate qualifications as illustrated in Figure VI. This information showed that the researcher managed to recruit participants who have wealth of knowledge, experience and skill in the field of mental health and vocational rehabilitation.

4.4 Findings and discussion

The research findings will be discussed in relation to the research objectives of this study as stated below:

Table 4.2: Research objectives as stated in 1.6

Research objectives	
i.	To determine the perceptions of occupational therapists when dealing with employees affected by MDD during WCE.
ii.	To identify current OT practices implemented during WCE of employees with MDD.
iii.	To develop a possible process of WCE with employees suffering from MDD.
iv.	To formulate the general occupational performances that the occupational therapist should assess to determine the WCE of employees with MDD.

The research aim and research objectives were used to guide the researcher throughout each phase of the research study. An electronic data management system was not available for the researcher during the analysis, hence the data had to be analysed manually. In phase one, the data were analysed using phenomenological and content analysis in which the perceptions and practices of occupational therapists were grouped according to themes and categories and their frequencies counted. From those findings the close-ended questionnaire for phase two

and open-ended questions for the interview guide in phase three were formulated. In phase two, the data were analysed using frequency distribution and percentages. Accordingly, the consensus level of 55% was chosen for this study as it is a new line of enquiry and the average response rate was 45.7%. Generally, there is no standard threshold for consensus. Barker and Burns[155] suggest a sliding threshold between 50% and 70%.

For clarity purposes, the following terms were used and need to be defined.

Theme: Group of items used as a means of understanding and clarifying the objective of the study.

Subtheme: Laser theme emerging from the main one.

Category: Items that are grouped together to complete or make a theme and share the same meaning .

Subcategory: Lesser category arising from the main one.

In phase three, the transcripts were written verbatim. The researcher used thematic analysis to compare and contrast similarities across the data and formulated five themes. As more themes emerged, the researcher grouped them into subthemes. As more categories emerged, the researcher grouped them into subcategories. An external auditor analysed the data and met the researcher to discuss the themes in order to reach a consensus regarding the generation of themes in the study. All the themes and categories were incorporated into diagrams and tables for member checking in phase four.

Different colour codings were used to differentiate the themes, subthemes, categories and subcategories as illustrated in Table 4.3.

Table 4.3: Colour coding system

Colour coding	
Theme	
Subtheme	
Category	
Subcategory	

During phase four, the themes were shown to the participants who made few alterations and agreed with most of the themes. After the researcher formulated all the themes, he noted that

they were helpful in answering the aim and objectives of the study. The themes and subthemes were then used as the headings and subheadings in answering the aim and objectives of the study. The themes were used to explore the objectives of the study as shown in Table 4.4.

Table 4.4: Research objectives and their themes

Research objectives	Themes
i) To determine the perceptions of occupational therapists when dealing with employees affected by MDD during WCE.	• The competency requirements of the occupational therapist (to perform WCE). • Formulating return-to-work decision.
ii) To identify current OT practices implemented during WCE of employees with MDD	• The content of comprehensive assessment for Work Capacity Evaluation.
iii) To develop a possible process of WCE with employees suffering from MDD.	• The process of WCE.
iv) To formulate the general occupational performance that the occupational therapist should assess to determine the WCE of employees with MDD.	• Occupational performance. • Formulating return-to-work decision.

The research aim was to describe the perceptions and practices of occupational therapists in determining work capacity of employees suffering from major depressive disorder. This was achieved by indirectly analysing the research objectives of this study.

4.4.1 Perceptions and practices of Occupational therapists in determining work capacity evaluation

From the various methods of data collection, the researcher and independent co-coders formulated themes that focused on current perceptions and practices of occupational therapists in determining work capacity of employees suffering from major depressive disorder. The researcher used the themes formulated in the focus group interview and member checking to easily and conveniently demonstrate the findings of this study.

Table 4.5: Themes determined in phase three (n=11) and confirmed in phase four (n=9)

Themes	Subthemes
1. The content of comprehensive assessment for Work Capacity Evaluation.	1. The physical layout of the OT practice. 2. Ways of obtaining medical information. 3. The value of interviewing. 4. Tools in the OT Department.

Themes	Subthemes
	5. Assessment of inappropriate illness behaviour. 6. Assessment at work. 7. Assessment at home.
2. The process of WCE	1. The reason for referral. 2. Information about the employee. 3. Interviewing the employee. 4. Collateral information. 5. Physical assessment or screening. 6. Psychosocial assessment. 7. Occupational performance. 8. Collateral information. 9. Formulating return-to-work decision.
3. The competency requirements of the occupational therapist (to perform WCE)	1. Occupational therapistsô knowledge. 2. Occupational therapistsô experience. 3. Occupational therapistsô skill.
4. Occupational performance	1. Performance skills. 2. Areas of occupation.
5. Formulating return-to-work decision	1. Employeeôs profile. 2. Employerôs point of view. 3. Employeeôs point of view. 4. Therapistôs point of view. 5. Declaring the employee as temporarily incapacitated. 6. Declaring the employee as permanently incapacitated. 7. Determinants of the employeeôs level of motivation.

4.4.2 Theme 1: The content of comprehensive assessment for work capacity evaluation

During data analysis, it was evident that the content of comprehensive assessment is very useful while performing work capacity evaluations.

A participant reflected:

- ñ...there should beé combination of assessment methods when doing a comprehensive assessment.ò
- ñ...the assessment must be comprehensive and it must not focus only on cognitive and affective components.ò

Literature control: The observation made by the participants reflected the recommendations of Fawcet[15] who writes that ñA comprehensive assessment provides an assessment that is both broad and deep and involves all or most of the domains of the single assessment processò (p.106). Such a comprehensive assessment should be objective and within a legal context[7] or for the purpose of establishing the capacity to return-to-work. This suggests that the occupational therapy assessment should involve all the domains of the assessment process and occupational performance. There is an agreement that a comprehensive assessment is very useful. Subthemes emerged around this subject and will be discussed later.

i) Subtheme 1: The physical layout of the occupational therapy practice

This subtheme did not emerge during phase one and phase two of data analysis in the study. It became evident during phase three, the focus group interviews.

- **Phase three**

Supporting reflections by the participants relating to "the physical layout" of the occupational therapy practice were:

- ⇨ ñThe requirements to perform a proper work capacity evaluation should focus on the practice environmental structure [rooms]....ò
- ⇨ ñ...there should be enough space [in the rooms] in the occupational therapy practice for the officeé interview roomé group therapy roomé .ò
- ⇨ ñThe assessment environment [rooms for evaluations/assessment area] should be quiet, warm and pleasant.... The room must not have distractions where people come in and out....ò
- ⇨ ñThe patient [employee] should be able to relax in the waiting area....ò
- ⇨ ñThere is a need for a good practice with equipment, furniture, computer with software and internet access and fax machine in order to perform reliable work capacity evaluation and good record keeping.ò

- **Phase four**

During phase four, **the participants' observations were:**

- ⇨ ñ...we need a good occupational therapy practice....ò
- ⇨ ñRecord keeping must be in order....ò

Literature control: The available literature on this matter corroborates the observation of the participants. For example, Mc Adams, Dacre, Sundgern, van der Vryfer, Omar, Meyer, Franzsen, Reddy[156] write that there must be a reception and waiting room, interview room, assessment room and large treatment area for group work which measures at least 4x4 metres. It is apparent from the literature and participantsô comment in this study that an occupational therapy practice should have each room allocated for a specific purpose such as the waiting area to wait for the consultation, an interview room to conduct interviews and for consultation, assessment room to perform work capacity evaluation and the treatment room for therapy.

ii) Subtheme 2: Ways of obtaining medical information

It is important to get very clear medical information on the employees who are referred for comprehensive occupational therapy assessment, including work capacity evaluation. There were no data relating to obtaining medical information in phase one and phase two. The subtheme of obtaining medical information emerged during phase three of the study.

- **Phase three**

Supporting reflections by the participants relating to "obtaining medical information" were:

- ⇨ ñ...depression affects women more than men.ò
- ⇨ ñIt is easier to say I canôt sleep, I canôt eat, I canôt cope at work or I feel depressed or my heart is bleeding...that goes with the stigma....ò
- ⇨ ñ...how they [employees] were functioning prior to the depression will help the therapist in determining the prognosis....ò

- ñIt is important to ask the employees with depression to bring their medication along during the assessment, to check if they are using it [medication]... whether they are on the correct dosages.ò
- ñ...assess if the clients are in their acute or chronic stage [of depression]... if they have received optimal treatment that included psychotherapy, occupational therapy and group therapy.ò
- ñ...have they used other forms of alternative therapies such as traditional doctors, aromatherapies, homeopathy?ò

- **Phase four**

When obtaining medical information, it was agreed during member checking that the categories in Table 4.6 will need to be taken into consideration.

Table 4.6: Ways of obtaining medical information (n=9)

Subtheme	Categories
Ways of obtaining medical information	• Gender (affects more women than men) • Pre-morbid functioning to assist with prognosis • Socio-economic status • Cultural expression of depression • The stage of depression (acute or chronic) • The employeeôs insight into condition • Stigma • Compliancy with medication and correct dosages • Stage of treatment • Alternative therapies • Optimal treatment (team approach)

Literature control: The literature on this subtheme concurs with the observations of the participants in both phases three and four. The key point was that it is essential for the occupational therapists to obtain medical information in order to have a clearer picture of the employee prior to the assessment. Fawcett[15] offers a comprehensive comment as follows:

> ñThe contextual factorsô are divided, by the World Health organisation into external environmental factors and internal personal factors. Internal personal factors include gender, age, coping style, social background, education, profession, past and current

experiences, overall behaviour pattern, character and other factors that influence how disability is experienced by the individualò (p48).

Thus, in both instances - the data from this study literature, the importance of collecting and reviewing medical data prior to contact with the worker and before beginning FCE/WCE was highlighted. Medical records yield background information such as diagnosis, date of onset, mental and medical history, precautions, medications, age and discharge plan ï all of which are crucial towards effective assessment of both the severity of MDD as well as reliable WCE[1,39]. Much as there was confluence between participantsô observations and the literature that the occupational therapist needs to have a full and clearer picture of the employeeôs medical history prior to the assessment and confirm some of the medical information during the interview, the literature highlighted some of the important aspects which were not mentioned by the participants such as date of onset, precautions and discharge plan.

iii) Subtheme 3: The value of interviewing

The first contact between occupational therapist and employee is during the interview. Mosey[110] underlines the significance of the interview by remarking that ñInterview is probably the most powerful, sensitive, and versatile evaluative instrument available to the occupational therapistsò (p.314). As such, the interview is an integral part of a comprehensive evaluation of a clientôs occupational functioning and is normally administered at the beginning of the assessment[112].

In all the phases of this study, the value of interviewing was seen as essential and appropriate especially with employees suffering from major depressive disorder. The findings are shown below according to the different phases of this research:

- **Phase one**

During phase one, 20 (72.3%) participants commented that an interview is a relevant method of evaluation for employees suffering from major depressive disorder as illustrated in Figure X below.

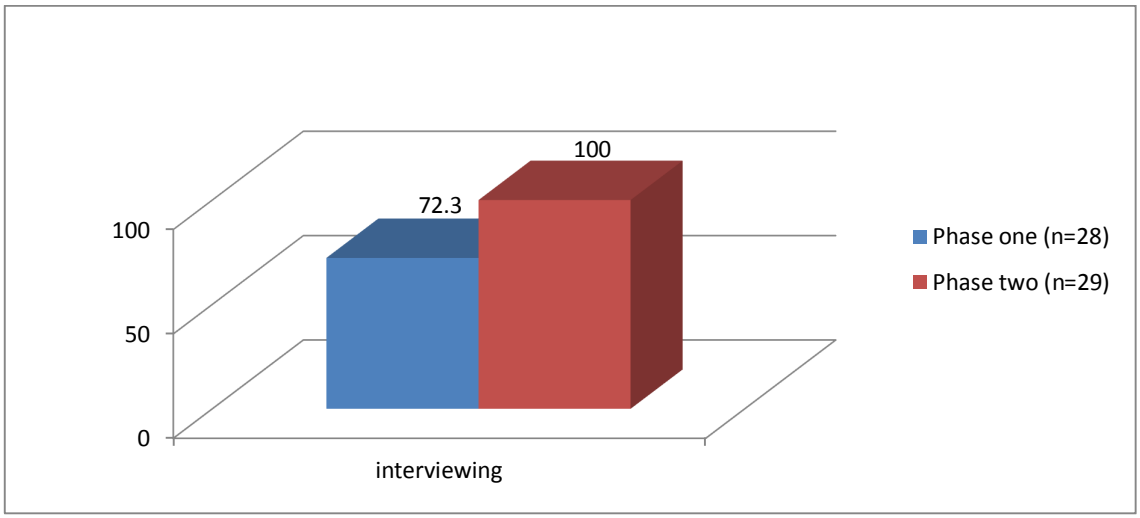

Figure X: The value of interviewing

- **Phase two**

All the 29 (100%) participants in phase two agreed that an interview should always be used during the initial stage of the assessment especially with employees suffering from major depressive disorder as illustrated above in Figure X.

- **Phase three**

Supporting reflections by the participants relating to "the value of interviewing" were:

- ñThe interview is vital with depressed clients [employees] to understand what they are going through.ò
- ñI think your diagnostic interview...or initial interview is critical since that will determine what follows afterwards [standardised measures and non-standardised assessments to use]....ò
- ñThe therapist needs to do a good comprehensive interview with the right questioning to get to the root of the problem... and address the real problem.ò
- ñ...ask questions about completed questionnaire to check the personôs [employees] reliability and to justify the assessment.ò
- ñThere is a need to perform an in-depth two hour interview...ask open-ended questions...and ask right questions.ò

- **Phase four**

The value of interviewing was also viewed, in this phase just like in the earlier ones, as essential for collecting information, assessment, determining reliability and clarification of information, confidentiality and understanding the employeeôs situation as shown in Diagram 1 below:

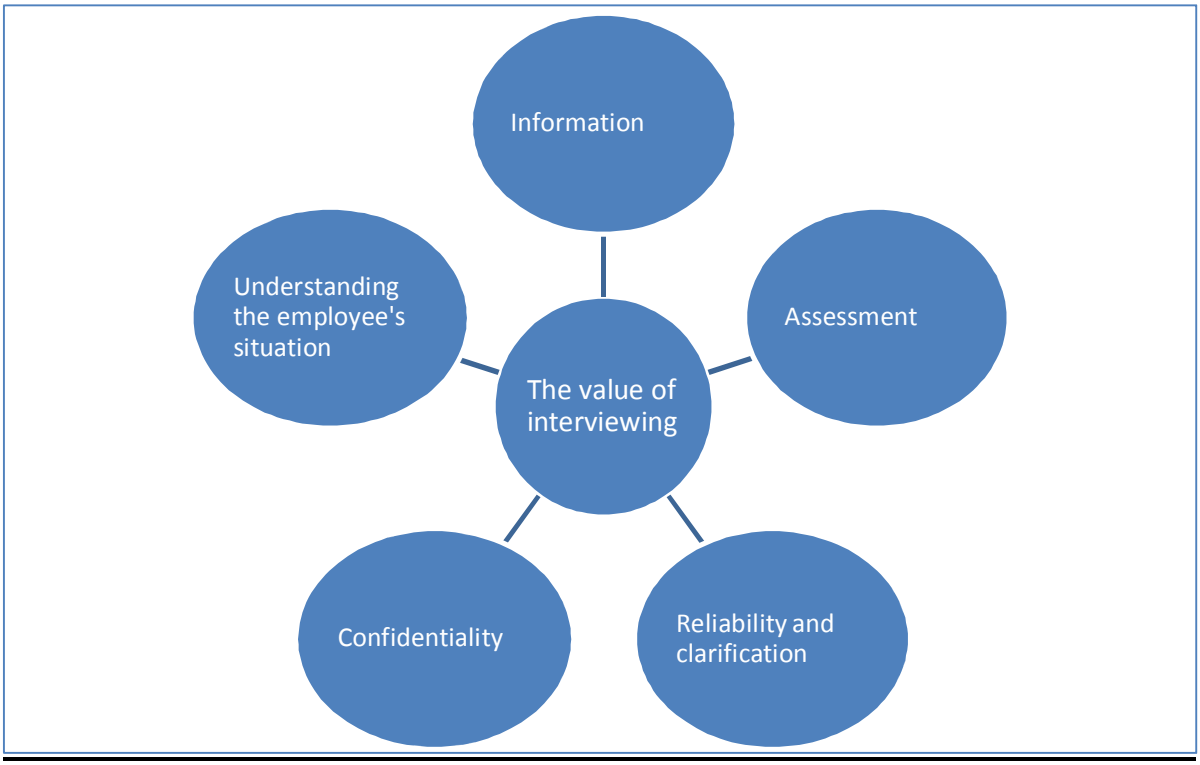

Diagram 1: The value of interviewing (n=9)

The participants' agreement relating to "the value of interviewing" were:

- ⇨ ñ...interview first before screening or evaluating and it will guide you....ò
- ⇨ ñThatôs true...an informative interview that lasts for two hours is very important.ò

Literature control: The literature consulted on this theme was congruence with the data from this study in that in both cases, the interview is usually chosen by the occupational therapist as the initial method of data collection and is viewed as a very useful method for collecting self-report data[10,15]. Although the participants in this study did not give details about set or fluid approaches to conducting interviews, the literature advises that there are multiple ways to conduct an interview and there is no single method that can be said to be

corrected[15]. According to the literature as well[112], an interview provides as for the following, all of which the participants pointed out, albeit in different words:

1) ñUnderstanding the employees story,
2) Building the therapeutic alliance,
3) Gathering information and developing occupational profile,
4) Observing behaviour,
5) Identifying clients strength and potential problem areas,
6) Clarifying the therapists role in the setting,
7) Establishing priorities for interventionò. (p.89)

In Diagram 1 of this studyôs findings, the value of interview was compared to the provisions of interviewing mentioned above:

Table 4.7: Comparison of literature control and the findings on the value of interviewing

Study findings	Literature control[112]
Information	ñUnderstanding the clientôs storyò
Understanding the employeeôs situation	ñbuilding therapeutic relationship and gathering informationò
Assessment	ñobserving behaviour, identifying clientôs strength and potential problem areas and developing occupational profileò
Reliability and confirmation	Reliability meant confirming what the employee told the therapist in comparison with the assessment findings. Collateral information or interviewing family members or employers. This aspect is not covered in the literature control
Confidentiality	ñbuilding therapeutic relationshipò - an element of trust between the occupational therapist and the employee

In other studies, interviewing was also found to be highly valued and used by therapists, with a user rate of 98%[157]. This shows that interviews are a reliable method of evaluation in the initial phase of the assessment especially with employees suffering from major depressive disorder.

A careful interview is essential to identify symptoms of MDD[52]. There are three broad categories of information that should be gathered during initial assessment[7]:

1. Health or medical information;
2. Information about occupational performance, and
3. More detailed information about the personôs work.

A study by Paykel and Priest[11], state that ñAn accurate recognition of depression in general practices depends on the skill of the interviewer, and training is most usefully directed at improving these skillsò (p.1199). Finlay[16] clarifies that questions should be designed to elicit information about a personôs occupational roles, daily routines, occupational behaviour settings, activity/occupational choices and critical life events. This further supports this studyôs findings that the interview is a valuable method for assessment.

The initial assessment of a client suffering from MDD is most likely to take the form of a semi-structured interview[7]. Crepeau, Cohn and Schell[112] suggested the following relevant interviews:

> ñOccupational Circumstances Assessment Interview and Rating Scale (OCAIRS) developed by Kaplan and Kielhofner (1989), The Occupational Performance History Interview-Second Version (OPHI-II) developed by Kielhofner, Mallinson, et al (2004), The Worker Role Interview (WRI), which is a semi-structured interview developed by Biernackie 1993 as cited in Willard and Spackmanò (p.351).

Others include The Work Environment Impact Scale (WEIS) a semi-structured interview developed by Corner, Kielhofner, & Oslon (1998) and the Canadian Occupational performance Measure (COPM) developed by Law et al, (1998) which is a client centred semi-structured interview geared to assist the occupational therapist to understand how the individual perceives their work environment[7].

Of these, The Worker Role Interview deserves special mention for its relevance to this study. It is based on the Model of Human Occupation, and help the occupational therapist ñto gain more in-depth understanding of factors such as the workerôs view of their abilities and limitations, their sense of commitment to the worker role, the impact of disability on their other roles, their ability to modify their habits and routines, and their perception of their work environmentò[7](p.136).

The structured clinical interview for DSM-IV-TR is the successor to known approaches of diagnostic assessment. Regarding interview, all diagnostic decisions are made by hand or by computer after all interview data are collected[27]. The structured clinical interview provides the scientist-practitioner with a reliable and valid means to assess the lifetime and current diagnostic histories of patients as well as the presence and severity of symptoms.

iv) Subtheme 4: Tools in the occupational therapy department

A variety of tools can be used for client assessment. Mosey[110] reminds us that the main tools of evaluation to assess psychosocial function and dysfunction ñare divided into three parts: interviewing, tools used for assessing performance skills and tools used for assessing areas of occupationò(p.314). Interviewing was addressed earlier. This subsection will address the tools that are used for assessing performance skills and areas of occupation. These tools are divided into standardised measures and non-standardised assessments.

a) Standardised measures

- **Phase one**

During phase one, a variety of standardised measures that are used to perform work capacity evaluation of employees suffering from MDD were suggested by the participants in this study.

Table 4.8: Standardised measures in phase one (n=28)

Formal tests	Frequency of participants	% of participants
MODAPTS samples for handwriting, reading, climbing stairs, walking	8	28.6%
WASP	8	28.6%
COTNAB	6	22.7%
VCWS 6	4	13.6%
BTE	1	4.5%
VCWS 9	4	13.6%
VCWS 201	1	4.5%
Rivermead Behavioural Memory Test	3	9.1%
CAM	3	9.1%
Thurstone work sample	3	9.1%
LOTCA	3	9.1%

Formal tests	Frequency of participants	% of participants
BaFPE	1	4.5%
JOULE®FCE	1	4.5%
COPM	1	4.5%
DTLA	1	4.5%
VMI	1	4.5%
TVPS 3	3	9.1%

- **Phase two**

The researcher developed phase two, close-ended questionnaire to determine the number of participants who agreed with the identified standardised measures in Table 4.8 above. The findings of the standardised measures in phase two are as follows:

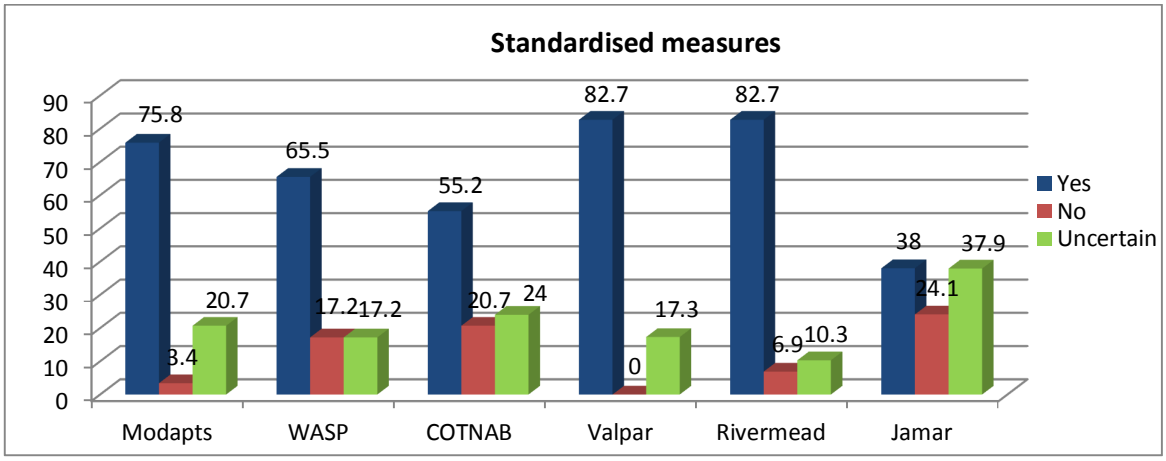

Figure XI: Standardised measures in phase two (n=29)

During phase two, the identified standardised measures were MODAPTS work samples for handwriting, reading and basic mathematics, WASP, COTNAB, Valpar Component Work Samples (refer to Figure XII) and Rivermead Behavioural Memory Test.

Twenty-four (82.7%) participants suggested different Valpar Component Work Samples as identified in Figure XII below:

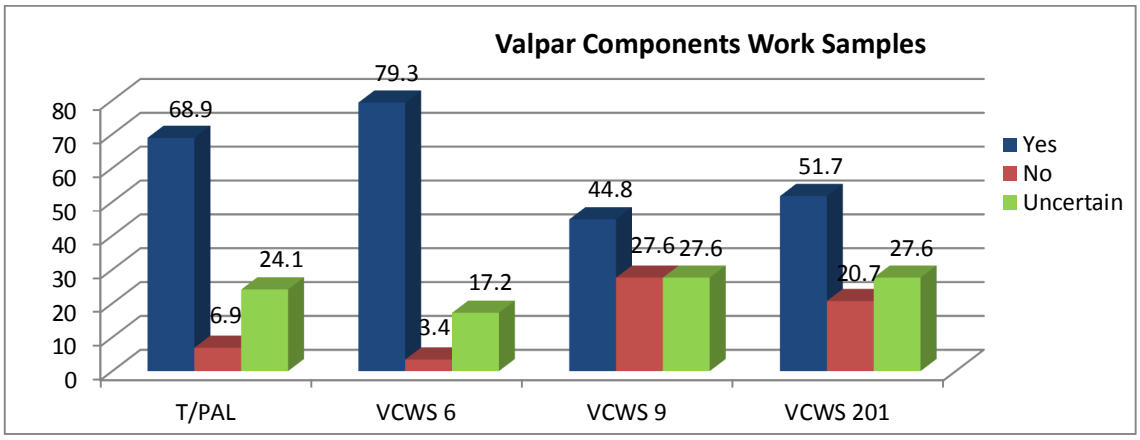

Figure XII: Valpar Components Work Samples in phase two (n=29)

The highly recommended Valpar Components Work Samples were the T/PAL and VCWS 6. The VCWS 9 and VCWS 201 did not meet the consensus level.

The other standardised measures are illustrated in Figure XIII, and the Clerical Assessment of Minnesota met the consensus level.

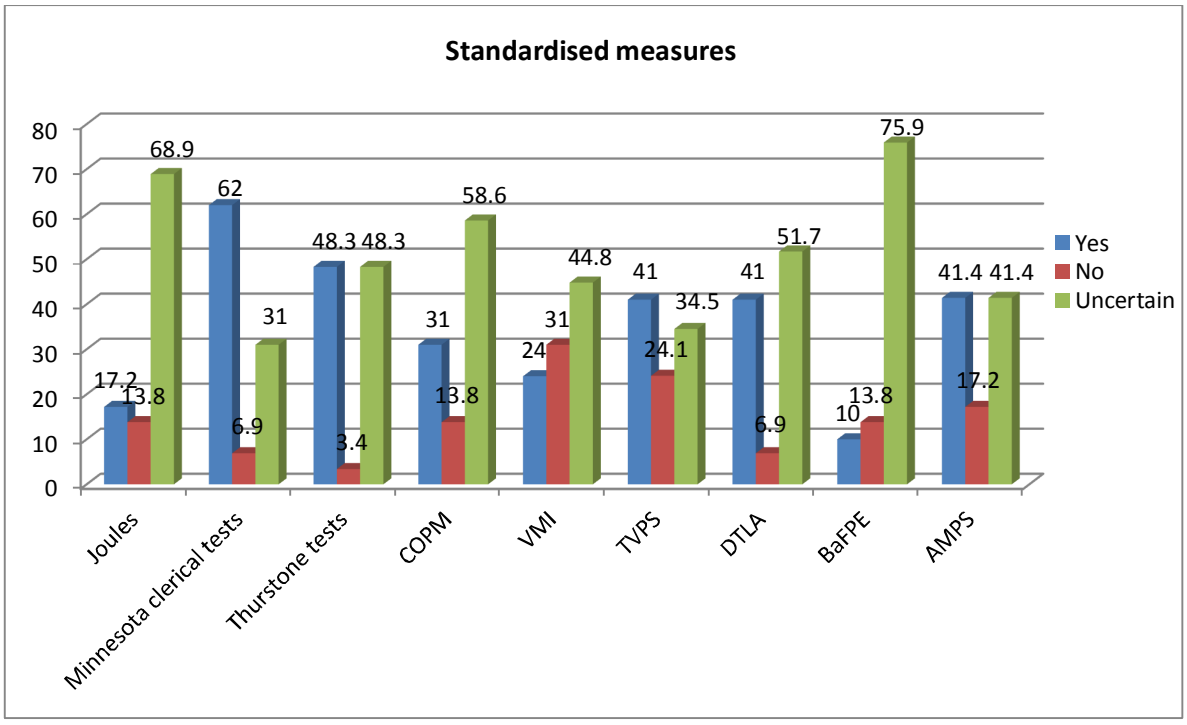

Figure XIII: Other standardised measures suggested in phase two (n=29)

The Mini-Mental Status Examination by Strunberg and The Ross Test of Higher Cognitive Process were considered important as illustrated in Figure XIV.

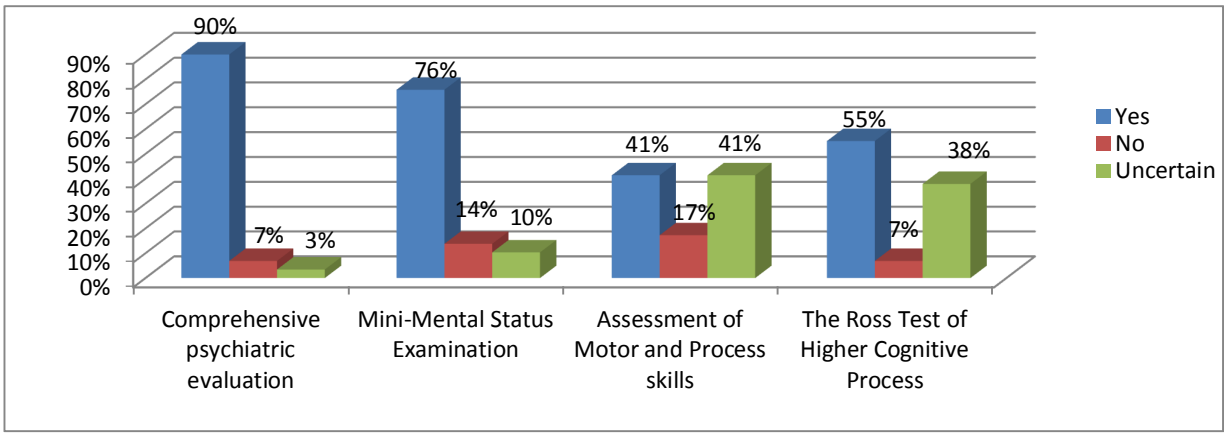

Figure X1V: Other suggested methods of evaluation (n=29)

- **Phase three**

Supporting reflections by the participant relating to "standardised measures" were:

- ⇨ ñYou do not need a million randôs of equipment to actually do a scientific functional assessment.ò
- ⇨ ñYou actually need basic MODAPTS samples for handwriting, climbing stairs, reading, walking and doing basic mathematics....ò
- ⇨ ñYou can also try the AMPS if you [therapist] want to score them performing basic activities of daily living.ò
- ⇨ ñ...standardised tools [measures] help you to quantify your findings...but you need the qualitative observations as well.ò
- ⇨ ñYou must not ignore your observations while using standardised tools [measures]....ò
- ⇨ ñThe more the therapist is unsure of what they are doing [the more] they fall into the trap of standardised tools.ò
- ⇨ ñThe WASP is good for its cognitive assessment....ò
- ⇨ ñI [participant] also like VCWS 6...the independent problem solving one... and VCWS 201...lifting and pulling task....ò
- ⇨ ñ...the mini-mental status examination works so nicely....ò
- ⇨ ñI [participant] like the Rivermead Behavioural Memory test...it [Rivermead behavioural memory test] was a reassurance for my patient who suspected memory

problems ...only to find that the memory was fine...it is brilliant.ò

- ⇨ ñAssessment is more complicated...you [therapist] need to make an accurate comprehensive assessment....ò

- **Phase four**

During phase four, the following standardised measures were accepted as illustrated in Table 4.9:

Table 4.9: Standardised measures during phase four (n=9)

Categories	Subcategories
Standardised measures	• Mini-mental status examination • Modapts work samples for handwriting, reading, walking, climbing stairs, mathematics and lifting • Assessment of Motor and Process Skills • Work Ability Screening profile (cognitive aspect) • Cognitive Assessment of Minnesota • Rivermead Behavioural Memory Test • Valpar 6 and 201 • T/PAL • Self report questionnaires

Supporting reflections by the participants relating to "standardised measures" were:

- ⇨ ñClinicians need to inform the patients [employees] on what they are going to do with them and there must be a room for discussion.ò
- ⇨ ñThe assessment must be comprehensive and you [occupational therapist] still have to apply decision making and clinical judgement while using standardised testing [measures]é .ò
- ⇨ ñA two day assessment is better, morning and afternoon on alternate [assessment] days...ò

The participants demonstrated clear awareness that standardised measures are important but only in as far as they are used in conjunction with other instruments.

Literature control: Literature confirms the significance use of standardised tests as a procedures to ensure the maximum level of consistency in a testing situation[112]. Test standardisation procedure ensures a common communication of assessment findings amongst the occupational therapists. There is a need for standardised measures which are valid, reliable, practical, safe and useful (utility)[1,6, 49,106,108,157].

The equipment used as standardised measures by the occupational therapists to carry out Work Capacity Evaluations include for example, Baltimore Therapeutic Equipments (BTE)[7,158], WEST[103,112,158], and TOWER[10,112,158] and the ERGOS work simulator[7,15]. The BaFPE is also a reputable standardised measure[44] but it did not meet the consensus level in this study. In this study, none of the just mentioned tests were suggested, leading to a possibility that they are not used by the South African occupational therapists.

The Canadian Occupational Performance Measure[15,18,15] and the Assessment of Motor and Process Skills[15,18,107] are the mostly used tests in the UK. In Fig XIII, it was found that the AMPS and COPM are the least used to assess employees suffering from MDD in phase two and the AMPS was confirmed in phase four after being suggested in phase 3. It is possible that the participants in phase three and phase four might have been trained to administer the AMPS which might be their reason for recommending it.

The Valpar Components Work Samples[7,10,15,103,158] is mostly used to assess functional work performance. Its purpose is to generate clinical and actuarial data on universal worker characteristics[112]. The most commonly used Valpar Components Work Sample in the UK is the whole body range of motion (Valpar Component Work Sample 9)[7]. In this study, the highly recommended Valpar Component Work Samples to evaluate employees suffering from MDD were VCWS 6, T/PAL and VCWS 201. The VCWS 9 was the least recommended for practices that evaluate employees with MDD.

Various studies conclude that clinical judgement is based on objective assessment arising from standardised measurements used, rather than intuitive guesswork, in that sense the occupational therapistsô decision making can become more rational and consequently defensible[15]. Therefore, the use of standardised measures is essential to support assessment findings. As Managh and Cook[44] maintain, ñWe need to develop assessments that meet our clinical responsibilities, our values, and our clientsô needsò (p.884).

b) The use of self-report questionnaires

- **Phase one**

The variety of self-report questionnaires that were suggested during phase one are listed in Table 4.10:

Table 4.10: Self-report questionnaires (n=28)

Self report questionnaires	Frequency of participants	% of participants (n=28)
BDI	8	28.6%
HADS	12	42.9%
Stress questionnaires	6	21.4%
Hamilton Rating Scale of Depression	4	14.3%
Zung depression scale	4	14.3%
Quality of life scale	4	14.3%
General Health Questionnaire	2	7.1%

The following important points were mentioned concerning self-report questionnaires:

a) They give self-reported information about the employeesô ability;
b) They help the therapist to be aware of the employeesô initiative, concentration, memory and quality of performance; and
c) They give self-reported information of the employeesô emotional status and work habits[7].

- **Phase two**

The self-report questionnaires mentioned in phase one, had their use confirmed during phase two of the study as illustrated in Figure XV.

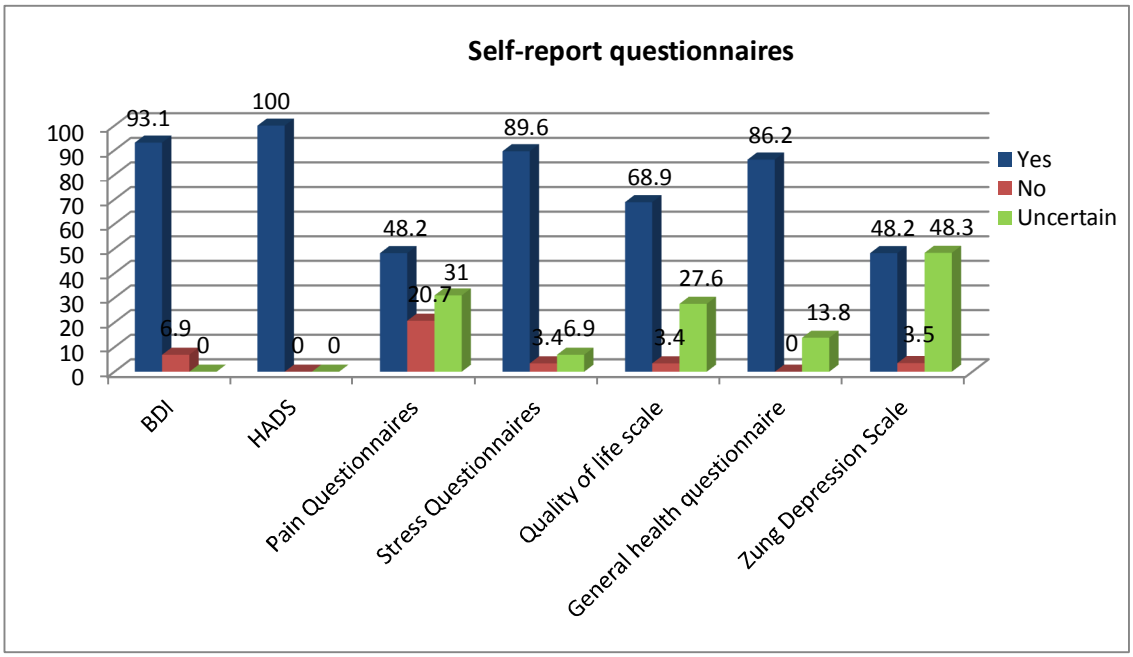

Figure XV: Self-report questionnaires in phase two (n=29)

The participants indicated using the following self-report questionnaires: HADS, Beck Depression Inventory (BDI), Stress questionnaires, Quality of Life Scale and General Health Questionnaire. The use of pain questionnaires with employees suffering from MDD did not meet the consensus level. This proves that the use of pain questionnaires was seen by the participants as not essential while assessing employees suffering from MDD. Suggested pain questionnaires to be used during WCE of employees suffering from MDD are as follows:

Table 4.11: Pain questionnaires (n=29)

Pain Questionnaires	Frequency of participants
Mc Gill Pain Questionnaire	3
Ransford Quantified Pain Questionnaire	3
Dallas Pain Questionnaire	2
Visual Analogue Scale	2
Million Visual Analogue	2
Oswestry Back Pain Disability Questionnaire	2

The most used pain questionnaires with employees suffering from MDD were Randsfordôs Quantified Pain Drawing and Mc Gill Pain Questionnaire. Generally, the use of pain questionnaires was very low from the participants. According to the researcher, this might be due to the fact that depression has a major influence on the employees mood and cognitive changes as stated in page 24 and 28 of this research study. In Table 2.1 (page 25), it was noted that depression has influence on biological changes such as pain. This brings an

argument if whether the occupational therapists need to assess the employees level of pain or not.

- **Phase three**

Supporting reflections by the participants relating to "self-report questionnaires" were:

- ⇨ ñThe Hospital Anxiety and Depression Scale (HADS) is effective...it looks at anxiety and the impact the anxiety has on the components of the mood...looks at depression over a week....ò
- ⇨ ñThe BDI looks at the vegetative signs as the results of Axis 3 rather than depression...how you feel now...the here and now.ò
- ⇨ ñThe therapists need to discuss the clientsô ratings on the questionnaire with them [employees] after they have completed them [questionnaires]...one [therapist] can pick up the inconsistencies... whether the depression is mild or severe....ò
- ⇨ ñThe life stress measure is also important...it gives an idea of how stress affects the personôs [employees] mood....ò
- ⇨ ñ...there is an interest checklist that establishes where the personôs [employeeôs] interest lies....ò

- **Phase four**

Supporting reflection by a participant relating to "self-report questionnaires" was:

- ⇨ ñI agree with the BDI and HADS but... please donôt interpret only...ask questions in relation to their [employees] responses....ò

Literature control: Just as The Hospital Anxiety and Depression Scale (HADS) was preferred by participants in this study, the literature also cites it as effective and frequently used to assess severity of anxiety disorders and depression in both somatic and psychiatric cases[159]. The HADS indicates how the respondent has felt in ñthe past weekò[159](p.4).

In other studies, the diagnosis of depression was independently checked using the Beck Depression Inventory (BDI)[29]. Beck Depression Inventory is particularly of value in high risk

groups such as clients suffering from MDD[11,15,157]. Self-report measures of depressive symptoms, such as the Beck Depression Inventory, represent a useful compliment to the structured clinical interview for DSM-IV when a clinician needs to understand the diagnostic history at intake and also needs a repeated measure of syndromal depression over the course of therapy. In this study, the participants mentioned that the BDI ñlooks at the vegetative signs as the results of Axis 3 rather than depression....ò There is a confluence between this study and Crepeau, Cohn, Schell[112], that the therapist needs to discuss the employeeôs response to the questionnaire upon their completion.

The other questionnaires, which were found to be of value were Stress Questionnaires, General Health Questionnaires and Interest check list. The pain questionnaires did not meet the consensus level, ñalthough the milder symptoms of depression have been found to influence the experience of painò[4](p.263). Clinician rated measures have also been developed for assessing depressive symptoms, most notably the Hamilton Rating Scale for Depression. This study focused on self-report measures since they are most useful to clinicians, particularly when repeated assessments are conducted in clinical practices.

The suggested pain questionnaires for employees suffering from MDD are Mc Gill Pain questionnaire[15,112,157], Visual Analogue Pain Scale[15,157] and Ransfordôs quantified pain drawing. The Visual Analogue Pain Scale is completed at the beginning and end of the evaluation[157] as pain is expected to increase with greater function[4]. The Mc Gill pain questionnaire is internationally recognised and it is classified as a valid and acceptable instrument for moderate to severe or acute pain[15]. ñIt consists primarily of three major classes of word descriptors, sensory, affective and evaluative, that are used by patients to specify subjective pain experienceò[15](p.269). The value of Mc Gill pain questionnaire agrees with the findings of this study. ñThe Visual Analogue Pain Scale on the other hand, uses a horizontal line of 100mm with ends labelled no pain on the left and unbearable pain on the rightò[15](p.57). This can guide in rating the level of pain.

c) Non-standardised assessment

Non-standardised assessments are recommended for their flexibility regarding procedure, setting and the manner in which the assessment is administered. For the most part, they are perceived as being more client-centred[15].

- **Phase one**

With reference to phase one of this study, identified non-standardised assessments are illustrated in Table 4.12.

Table 4.12: Non-standardised assessment (n=28)

Non-standardised assessments	Frequency of participants	% of participants (n=28)
Activities	10	36%
Clinical observation	14	50%
Document analysis	1	3.6%
Cross checking	12	42.8%
Work visit	14	36.4%
Job analysis	3	10.7%
Home visit	3	10.7%

- **Phase two**

In phase two, the highly recommended non-standardised assessments for performing WCE of employees suffering from MDD were document analysis, activities, clinical observations, cross checking, home visit, work visit and job analysis as illustrated in Figure XVI.

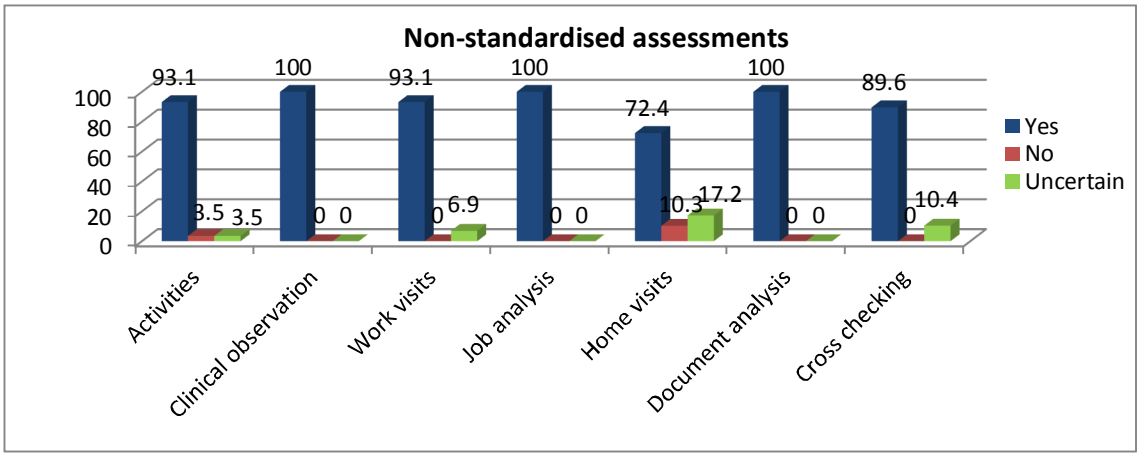

Figure XVI: Suggested non-standardised assessments in phase two (n=29)

- **Phase three**

Supporting reflections by the participants relating to "non-standardised assessments" were:

- ⇨ ñOur activities [occupational therapyôs use of purposeful activities] are powerful...I promise...we [therapists] need to go back to the basic use of activities for assessment and treatment...and observe clients [the employee with MDD]....ò
- ⇨ ñ...go back to the roots of occupational therapy...activities.ò
- ⇨ ñEngaging our clients [employees] in practical activities and clinically observing them will give us information about their task performance and level of motivation....ò
- ⇨ ñ...check [therapist] if the assessment is as comprehensive and complete as possible ...not some of the tests that the therapists are falling into their [standardised measures] trap...they [therapists] are not engaging or talking to the clients [employees] anymore...the more you [therapist] are unsure of what you are doing... you will fall into the trap of the standardised test...ò
- ⇨ ñWe need to have our clientôs [employees] in a group setting where it will be easy to observe their interactions... preferably task centred groups...practical groups where the clients [employees] are engaged in activities.ò
- ⇨ ñ...the home environment is giving us [therapists] big collateral information...ò
- ⇨ ñ...you [therapist] will be shocked of the clients [employeeôs] interpersonal relationship at work...donôt undermine work visit...ò

- **Phase four**

The non-standardised assessments illustrated in Table 4.13, were accepted in phase four.

Table 4.13: Non-standardised assessments in phase 3 (n=11)

Categories	Subcategories
Non- standardised assessments	• Activities • Practical groups • Clinical observations • Work visit • Home visit

Supporting reflections by the participants relating to "non-standardised assessments" were:

- ñ...suggested activities to use for assessment are wire core-tail, bead making, making tea and other simple crafts.ò
- ñ...this is true...I still like activities and practical groupsé .ò
- ñ...please observe...the observations are very important...you [therapist] will see a lot...ò

Literature control: According to the literature consulted, non-standardised assessments are useful for observing the persons functional ability in their home environment, as well as addressing the qualitative aspects of performance and exploring the relationship between the client and carer[15]. This observation matches that of the participants in this study concerning the value of clinical observation and its efficacy in addressing the qualitative aspect of assessment. It is crucial for the occupational therapist to use good observational skills throughout the assessment to ensure the safe performance of an employee[112] and consistency in effort throughout the assessment. Therefore, observational skills were considered key to observing the employeeôs inconsistencies, performance during activity participation and level of motivation while executing tasks in this study as well as the literature.

Engaging employees in activities was found to be a powerful tool in this study as reported by one participant that ñwe [occupational therapists] need to go back to our roots...ò which is the basic use of activities. A survey of Occupational Therapy Practitioners in Mental Health, states that occupational therapists have gone outside the profession, perhaps due to the shortage of occupational therapy specific courses or the external pressure to generic working[18]. However, there is continuing debate about the value of therapeutic activities; using activity based treatment rather than talking based treatment[18].

There is consensus however, about engaging employees in a ñgroup settingò[10] where it will be easy to observe their interaction in which employees are engaged in activities. It was also found that the most frequently attended type of occupational therapy intervention was task oriented groups[160].

There is also agreement between this study and the literature about the important use of non-standardised assessments such as activities, documents analysis, clinical observations and cross checking for triangulation[15,112]. The point that needs to be taken into consideration is that there is a strong need to reduce the error in WCE that comes from non-standardised protocols[4]. Even though non-standardised assessments were found to be effective in this study, the issue of lack of evidence and publications about their validity should be noted in the near future. Therefore, the use of standardised measures and non-standardised assessments is still a challenge during Work Capacity Evaluation.

The differences in phase one and two findings, was that in phase one, the participants had to volunteer their knowledge and phase two guided to either agree or disagree with the non-standardised assessments as illustrated in Figure XVI.

c) Common complexities experienced during Work Capacity Evaluation

From the above findings and discussion, different standardised measures and non-standardised assessments were highlighted as valuable in performing a comprehensive Work Capacity Evaluation. During phase one, there were issues of concern related to performing Work Capacity Evaluation which were included in the close-ended questionnaire in phase two for confirmation. Findings of this process are illustrated in Table 4.14. These concerns were not discussed further in phase three and phase four.

Table 4.14: Common complexities experienced during WCE in phase two (n=29)

Complexities during work capacity evaluation	Yes (%)	No (%)	Uncertain (%)
We have few standardised measurements to look at psychiatric types of symptoms	26 (89.6%)	1 (3.4%)	2 (6.9%)
Most of our tests focus a lot on cognitive aspects and not on psychosocial and or vocational aspects	17 (58.6%)	7 (24.1%)	5 (17.2%)
We experience difficulties in assessing the influence of the work environment on the client	18 (62.1%)	9 (31%)	2 (6.9%)
We have difficulties in assessing the existence of victimisation by the supervising staff/colleagues	23 (79.3%)	5 (17.2%)	1 (3.4%)
We have difficulties in predicting specific ability to cope at work	17 (58.6%)	9 (31%)	3 (10.3%)

Complexities during work capacity evaluation	Yes (%)	No (%)	Uncertain (%)
It is difficult for the therapist to extrapolate from the clinical assessment the real life situation especially with regard to social skills	11 (37.9%)	12 (41.4%)	6 (20.7%)
Therapists underestimate their own clinical knowledge and clinical observation skills, and rely too much on formal tests	18 (62.1%)	5 (17.2%)	6 (20.7%)
Therapists experience difficulties in handling patientsô manipulation and therapists are being sympathetic to patients.	8 (27.5%)	13 (44.8%)	8 (27.5)
Many OTs who perform FCEs are not experienced in the field of psychiatry. Their level of knowledge in work capacity evaluation is a major concern.	23 (79.3%)	2 (6.9%)	4 (13.8%)
We have difficulty in assessing clientôs work load or work pressure	18 (62.1%)	7 (24.1%)	4 (13.8%)
There is not enough awareness of case management opportunities or other mental health rehabilitation providers	24 (82.7%)	2 (6.9%)	3 (10.3%)
I feel that assessment of malingering needs more scientific guidelines for the occupational therapists	22 (75.8%)	5 (17.2%)	2 (6.9%)
It is difficult to determine a conclusion when the pre-morbid level of functioning is high and the impact of functioning is subtle	19 (65.5%)	5 (17.2%)	5 (17.2%)

There was an agreement on most of the factors in Table 4.14 except the following:

1. It is difficult for the therapist to extrapolate the clinical assessment to the real life situation especially with regard to social skills. There was disagreement with regard to this statement as therapists use practical groups and collateral information to comment about social skills.
2. Therapists experience difficulties in handling manipulative patients and therapists are being sympathetic. There was no consensus on this statement. The participants felt that they could not be easily misled or manipulated by clients. This means most participants were of the opinion that they had enough trust in their skills to deal with this potential problem.

Literature control: Ross[7] observes that a criticism focusing on the equipment used for evaluation is the disregard of environmental factors, which is a barrier to returning to work. The Person-Environment-Occupation Model emphasizes the complex, dynamic relationships amongst the person, the environment, and the occupation[112]. Vessby and Kjellberg[161] correctly point out that ñParticipation can be limited or facilitated by both physical and social environments which include lack of money, limited transportation, physical difficulties and a lack of social networks are examples of environmental issues that can hinder participation in occupationò(p.323). The occupational therapy WCE should evolve around the Person-Environment-Occupation Model because as Fawcett[15] observes, the therapist must strive to use all of the available information and observations to estimate the clientôs underlying capacity. Fawcett[15] reported several key reasons why occupational therapy assessment is complex and it relate to:

- ñNature of therapeutic practice;
- Nature of human occupation and occupational performance;
- Complexity of measuring human function;
- Influence of the level of task demand;
- Impact of familiarity on performance;
- Influence of environment on performance, and
- Constraints of the practice settingò (p.33).

This key reasons are not related to the occupational therapistsô competencies.

v) Subtheme 5: Assessment of inappropriate illness behaviour

Inappropriate illness behaviour or abnormal illness behaviour is the term used to describe the actions of a person whose complaints and symptoms are not related to any possible underlying organic cause[22]. While performing WCE with employees suffering from MDD, the occupational therapist should be able to exclude inappropriate illness behaviour, otherwise it will negatively affect the assessment findings.

- **Phase one**

During phase one of the study, the assessment points in Table 4.15 were found to be essential to exclude inappropriate illness behaviour.

Table 4.15: Inappropriate illness behaviour in phase one (n=28)

Category	Frequeny	Percentage
Cross-checking for inconsistencies	23	82.1%
Clinical observation	7	25%
Collateral information	7	25%
Any secondary gains	4	14.2%
Addition of other diagnosis in Axis 1, 2, 3	3	10.7%
Axis 4: Poor support system	9	32.1%
Axis 4: Poor socioeconomic factors (finances)	8	28.6%

- **Phase two**

The above categories were confirmed in phase two as follows:

In Figure XVI, 26 (89.6%) participants agreed on the use of cross checking to check for inconsistencies, 29 (100%) participants agreed on clinical observations during WCE. The need to always check for other diagnosis in Axis 1 and 3 was underlined in phase one as suggested by the participants that Axis 1 and 3 will affect the employeeôs performance as well.

a) Influence by other diagnosis in Axis 1

The following diagnoses in Figure XVII, anxiety disorder, Post Traumatic Stress Disorder, substance abuse and paranoid schizophrenia might negatively affect the therapistôs Work Capacity Evaluation of employees with MDD.

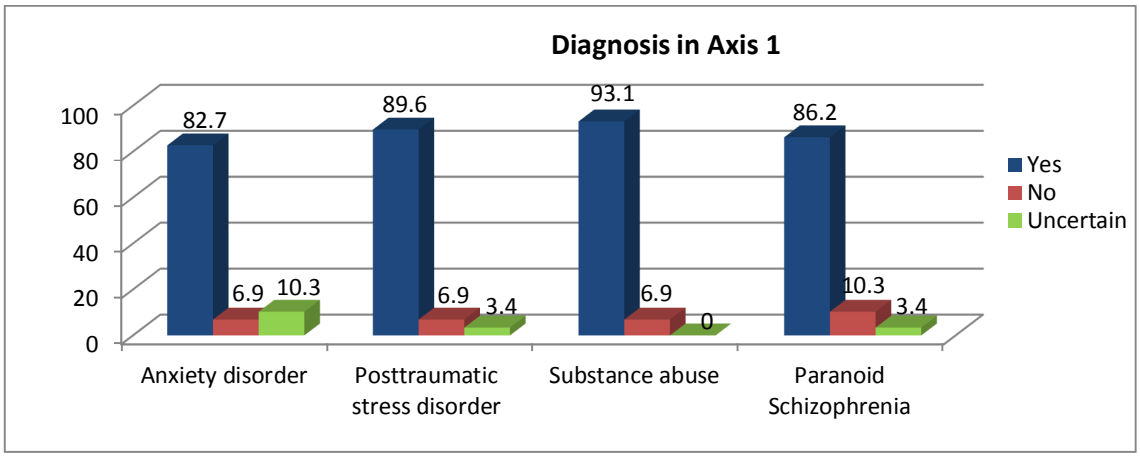

Figure XVII: Other diagnoses that affect work capacity with MDD employees in phase two (n=29)

b) Influence by other diagnosis in Axis3

The following diagnoses in Figure XVIII, HIV/AIDS, chronic fatigue, chronic pain, organic brain syndrome and aspergers, might negatively affect WCE of employees suffering from MDD.

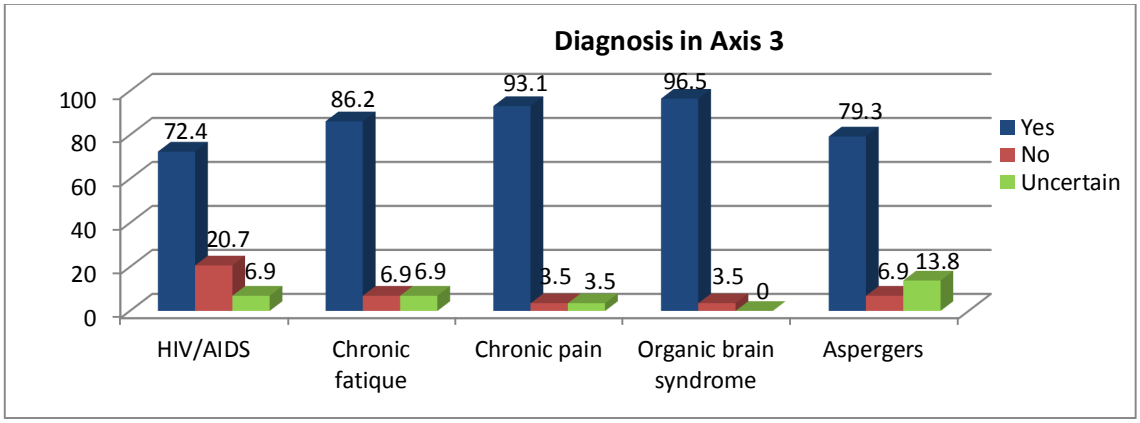

Figure XVIII: Other diagnoses in Axis 3 that influence work capacity of MDD (n=29)

c) Support system

It was found that Axis 4, which includes poor support system at home and at work will influence the employeeôs suboptimal effort during evaluations and it might result in inappropriate illness behaviour as illustrated in Table 4.16.

Table 4.16: Support system (n=29)

Influence of support system	Yes (%)	No (%)
Lack of social support structure (social structure)	89.6	10.4
Poor insight from clientôs family regarding his/her illness (familyôs insight)	86.2	13.8
Poor insight from clientôs employers regarding his/her illness (employerôs insight)	93.1	6.9
Negative family relationship/interference (Family interference)	93.1	6.9
Employerôs attitude towards the client with mental illness (employerôs attitude)	89.6	10.4
Employerôs unwillingness to consider reasonable accommodations (no reasonable accommodation)	96.5	3.5

d) Socioeconomic factors

In phase two, it was noted that employeeôs lack of funds and poor access to work or a need for finances will affect the employeeôs willingness to return to work which will result in inappropriate illness behaviour as illustrated in Table 4.17.

Table 4.17: Socioeconomic factors (n=29)

Influence of socioeconomic factors	Yes (%)	No (%)
Lack of funds which leads to non-compliance to treatment/therapy (treatment funds)	93.1	6.9%
Poor access to resources such as transport, job advertisement and corporate clothing (Resources)	100	0

- **Phase three**

Supporting reflections by the participants relating to "inappropriate illness behaviour" were:

- ⇨ ñ...malingering is a diagnosis that could be made by a psychiatrist...rather use inappropriate illness behaviour....ò
- ⇨ ñDuring assessment, there is always 25% inconsistencies and that is normal...50% inconsistencies then you [therapist] may consider inappropriate illness behaviour since it is a big figure...compare self-report and observations....ò
- ⇨ ñ...use multiple assessment methods and triangulate....ò
- ⇨ ñWe [therapists] are not in a position to judge clientôs [employeeôs] behaviour...or to catch the client...you can comment about suboptimal performance or inappropriate

illness behaviour....ò

- ⇨ ñ...donôt ignore inconsistencies in effort....ò
- ⇨ ñIf there is suboptimal performance...then there is a question of any Axis 1 or 2 or 3 or 4.ò
- ⇨ ñ...look for possibilities of personality disorders such as antisocial personality disorder, borderline personality disorder, avoidant personality disorder, dependent personality disorder, hypochondriasis, obsessive compulsive disorder and so on....ò
- ⇨ ñOnce you [therapist] suspect Axis 2...you will be uncomfortable...your discomfort as a therapist should tell you that there is something wrong [with the employee]....ò
- ⇨ ñIf you [therapist] feel drained and exhausted by a patient [employee], then start thinking of Axis 2é .ò

- **Phase four**

During phase four, Table 4.18 was shown to the participants with regard to the assessment of inappropriate illness behaviour.

Table 4.18: Inappropriate illness behaviour (n=9)

Subtheme	Categories
Inappropriate illness behaviour	• Inconsistencies • Check for other diagnoses in Axis 3 and 4 due to symptom exaggeration • Look for possibilities of personality disorders (Axis 2) • Suboptimal effort during performance • Any symptom exaggeration • Level of motivation

Supporting reflections by the participants relating to "inappropriate illness behaviour" were:

- ⇨ ñ...thatôs where experience counts in identifying personality disorders...otherwise you [therapist] will miss the point.ò
- ⇨ ñ...take inconsistencies in effort and suboptimal effort in performance seriously...find out why....ò

- ñ...are they [employees] motivated to execute your [therapist] request...or they just do it...?ò
- ñDo you [therapist] suspect exaggeration of symptoms?ò
- ñ...that is where experience is definitely needed.ò

Literature control: The assessment of inappropriate illness behaviour (malingering) is a challenge and is difficult to detect. However, Sadock and Sadock[28] offer the following useful advice:

> ñMalingering should be strongly suspected if any combination of the following is noted (1) medico-legal context of presentation, (2) evident discrepancy between the individualôs claimed stress or disability and the objective findings, (3) lack of cooperation during the diagnostic evaluation and in complying with the prescribed treatment regimen, and (4) the presence of antisocial personality disorderò(p.887).

Thus, malingering is summarised as the total faking of illness or injury[4] due to secondary gain. Secondary gain is frequently mentioned in FCE/WCE as a factor related to poor effort/submaximal effort. It may not directly impact function, but may be associated with other variables that have a more direct impact on activity[4].

According to literature there are some ñpsychiatric disorders associated with depressionò as in Baumann[34] as shown below:

Table 4.19: Psychiatric disorders associated with depression

Psychiatric disorders associated with depression
Mood disorders
Anxiety disorders
Psychotic disorders
Substance abuse disorders
Eating disorders
Adjustment disorders
Somatoform disorders
Personality disorders

There is agreement between the study and literature about psychiatric conditions such as anxiety disorder, substance abuse disorder and psychotic disorders (paranoid schizophrenia) that these are sometimes associated with MDD.

According to literature consulted on the subject, the following medical conditions are associated with depression as shown in Baumann[34].

Table 4.20: Conditions associated with depression

Neurological disorders
Epilepsy Multiple sclerosis Parkinsonôs disease Cerebrovascular disease Trauma
Endocrine disorders
Adrenal disorders (Cushingôs Addison) Thyroid disorders Parathyroid disorders Menses-related
Infectious and inflammatory disorders
HIV/Aids Infectious mononucleosis Systemic Lupus Erythamotosis (SLE) Tuberculosis Rheumatoid arthritis
Miscellaneous disorders
Malignancies (pancreatic CA) Uraemia and other renal diseases Vitamin deficiencies Cardiopulmonary disease

There is an agreement between this study and Table 4.20 (infections and inflammatory disorders) about HIV/AIDS and neurological disorders as associated with depression. According to analyses of the Medical Outcome Study, if depression co-exists with chronic illnesses, the disability impact is addictive. For example, the disability due to depression and heart disease has been found to be twice that of heart disease alone[68]. Thus, employees who suffer from depression and other medical conditions are a challenge and it is not easy to return them to the workplace. Be that as it may, it must be remembered that the goal of WCE is to return the employees to the workplace despite co-existing conditions.

Crouch and Alers[10] found out that clients with supportive families were more likely to adjust to the demands of the world of work and experienced employment success compared to those

lacking family support. Information from additional informants (collateral information) can be helpful in clarifying the course of current or prior MDD[52].

vi) Subtheme 6: Assessment at work

- **Phase one**

In Table 4.12, 14 (36.4%) participants considered work visit to be an essential method during WCE. Three (10.7%) participants suggested the use of job analysis as essential during WCE.

- **Phase two**

In Fig XVI, there was an agreement amongst 27 (93.1%) participants concerning the need to conduct a worksite visit during WCE as it ascertains the employeeôs performance and interpersonal relationship at work. Twenty-nine (100%) participants confirmed the usage of job analysis to compare the job and the employeeôs performance at work as part of triangulation to assessment information given to the therapist.

- **Phase three**

Supporting reflections by the participants relating to the necessity of "worksite visit" were:

- ⇨ ñWorksite visits assist to see the impact of the clientôs [employeeôs] interpersonal relationship at work.ò
- ⇨ ñWorksite visits are very challenging for the occupational therapists...as you donôt always get good cooperation [from employers]é .ò
- ⇨ ñ...use work samples that give you [therapist] a clear criteria that you [therapist] can take along to the employer ...if you donôt have a baseline knowledge of the patient ...it is so vague to negotiateé .ò

- **Phase four**

Supporting reflections by the participants relating to "worksite visit" were:

- ⇨ ñ...thatôs where the knowledge of the world of work comes iné .ò
- ⇨ ñ...know the job...know the environment...and interpersonal relationships at work....ò
- ⇨ ñIt is helpful to do the worksite visit with the client [employee]...you [therapist] can see how they are functioning with the manager...you can see that they [employees] are not coping with the environment...they [employees] are dissolving...ò

Literature control: Before the occupational therapists can conclude about the employeeôs work capacity to perform their work duties, it is essential for the occupational therapist to have insight about the employeeôs job. This is so especially as work performance supports participation and productivity, which are essential to health and well-being of each employee[112]. There should be a clearer picture of whether the employee has the capacity to perform their duties productively. This will lead to an urgent need of performing the worksite visit mentioned above.

A worksite visit will give an occupational therapist some understanding of the person, both as a worker and as occupational being beyond the workplace[7]. During this study, a worksite visit (Table 4.12, Fig XVI) was found to be an essential method of evaluation, to assess the job, employeeôs performance and interaction with others in the workplace and the employerôs view of the employee. Workplace assessment is mostly qualitative in nature[7]. It also gives the occupational therapist an opportunity to interview the management and colleagues regarding the employeeôs behaviour, work habits and work performance.

It might be beneficial to perform WCE on site at the workplace[4]. Performing WCE in the workplace will assist the occupational therapist to compare whether more general FCE/WCE is more highly related to actual job performance[4]. The occupational therapist may get the opportunity to perform the job analysis (Fig XVI) to know the nature and demands of the clientôs job during the worksite visit. It is just as Crepeau, Cohn, Schell[112], observe that, ñA formal job analysis is desirable to measure the employeeôs ability to work at a specific job along with the written company job descriptionò because ñjob analysis is a dynamic process that is appropriate to all practice settings that consider the worker, work environment, and

work demandsò (p.619). It involves measuring the workspace, and that includes measuring the dimensions of reach required for the various tasks, the distance required to deliver or move items, the work heights, the weights of objects that are lifted up or down, their frequency, duration, distance and quality of the task, such as handles, or the stability of the weights to be lifted[112]. Other forces that the worker encounters are also measured, such as pulling, pushing, use of tools and protective equipment. The body positions of the worker such as reaching, leaning, bending and other postures are also measured[112].

vii) Subtheme 6: Assessment at home

- **Phase one**

In Table 4.12, three (10.7%) participants felt that it was essential to do a home visit or to assess the employee at home as part of the assessment.

- **Phase two**

In Fig XVI, 21 (72.4%) participants confirmed the use of home visits as essential, to assess the clients at their home.

- **Phase three**

Supporting reflections by the participants relating to "home visit" were:

- ⇨ ñ...the home environment is giving a big [sic] collateral information....ò
- ⇨ ñ...home visit must be unannounced....ò
- ⇨ ñ...do not get [therapist] emotionally involved with the clientôs [employeeôs] living conditions or home circumstances, while doing the recommendationsé .ò
- ⇨ ñ...if they [employees] canôt cope at home...they canôt cope at work...ò

- **Phase four**

Supporting reflections by a participant relating to "home visit" was:

⇨ ñ...sometimes it is worth it to assess the client [employee] at their home...ò

Literature control: This study found out that it is important and effective to assess the employees at their homes if it is necessary. Similarly, literature cites the importance of home visits, for example, through Crepeau *et al.*[112], who write that ñThe occupational therapists assess clientsô (employeesô) home environments to ensure that the home environment is safe and the clientôs ability to remain in the homeò (p.827). Standardised home assessments can be used in conjunction with photographs of home environment to document the current situation in the home[112]. Occupational therapist must place the patientsô priorities at the centre of the home visit process[20].

4.4.3 Theme 2: The process of Work Capacity Evaluation

During phase one and phase two, the process of Work Capacity Evaluation was not discussed. The discussion commenced in phase three.

- **Phase three**

Supporting reflections by the participants relating to "process of Work Capacity Evaluation" were:

⇨ ñThere is no exact procedure to follow in the field of work capacity evaluation, flexibility is important.ò

⇨ ñIt is important for the therapist to always clarify and answer the reason for the referral.ò

⇨ ñYou [therapist] need to know the employeeôs job...find out if they [employees] have a job... make sure you know the job...ò

⇨ ñ...continue with the perusal of documents (available medical reports, sick leave records, attendance records, performance management records and job

description)....ò

- ⇨ ñ...you [therapist] need to get the background information and identify current problems [of the employee]é ..ò
- ⇨ ñ...through collateral information from the family and employer...confirm the information...ò ñ...see family member face to face if possible and not over the phone for collateralé .ò
- ⇨ ñ...continue [the therapist] with physical assessment...followed by psychosocial assessment....ò
- ⇨ ñ...discuss the questionnaires and social information clarification with the client [employee]...ò
- ⇨ ñ...this will be followed by WCE using work samples and informal assessments [non standardised assessments...ò
- ⇨ ñ...if there is a need for further information...the therapist may need to perform the worksite visit....ò
- ⇨ ñ... record all the information with the Human Resources Manager (HR)....ò
- ⇨ ñ...the process will be completed by making the decision of returning the clients [employee] to worké whether that is possible or not....ò

- **Phase four**

Diagram 2 was shown to the participants during phase four of member checking. Few corrections were made regarding the flow of the diagram and it was accepted by the participants as an effective depiction of the process of Work Capacity Evaluation.

Literature control: The process of Work Capacity Evaluation assists the occupational therapist to be systematic while performing WCE. Jahn, Cupon, Steinbagh[158], states that ñThe process of FCE/WCE draws upon the principles of biomechanics, ergonomics, kinesiology and physiologyò (p.2). This explains why in this study, participants cited logical assessments processes. Following Fawcettôs[15] advice and the participants response in 1,2,3 and 9, such a process might require the therapist to:

1) ñ...clearly understand the reason for the referral from the referring sourcesé .ò

determine what information is necessary to make sound clinical decisions and clarify what information is to be collected;

2) ñ...interview the employee to get their life storyò;
3) ñ...get collateral information from relevant sources such as family, colleagues, referral sources, treating specialists...ò;
4) Choose appropriate standardised measures to support non standardised assessment methods;
5) Undertake data collection procedure such as records/referral review, interview, observations and administration of standardised measures;
6) Score standardised measures;
7) Analyse data;
8) Interpret data;
9) ñ...get collateral information...ò from the family or employer in order to confirm some of the findings, and
10) Report the results in writing (p.46).

In this study, it was reported that therapists need to collect information pertaining to the employeeôs job and work history, medical reports and attendance records at work. Also, it was concluded that the therapist should perform physical screening/assessment, followed by psychosocial and functional assessment using standardised measures and non-standardised assessments. Eventually, it was mentioned that the practitioner would then have to decide whether the employee can return to work or not.

Even though the process of WCE encourages a logical sequence of steps, the occupational therapists need to be flexible as the process guides them. Roley, Delany and Barrows, Brownrigg, Honaker, Sava, Talley, Voelkerding, Amini, Smith, Toto, King[20] warn that the process does not always occur in a sequenced step by step fashion, instead it is dynamic and allows occupational therapy practitioners to practice with an ongoing focus on outcome while constantly changing the overall plan to accommodate changes along the way.

This observation concurs with that of the participant who remarked that ñthere is no exact procedure to follow in the field of Work Capacity Evaluation, flexibility is important.ò

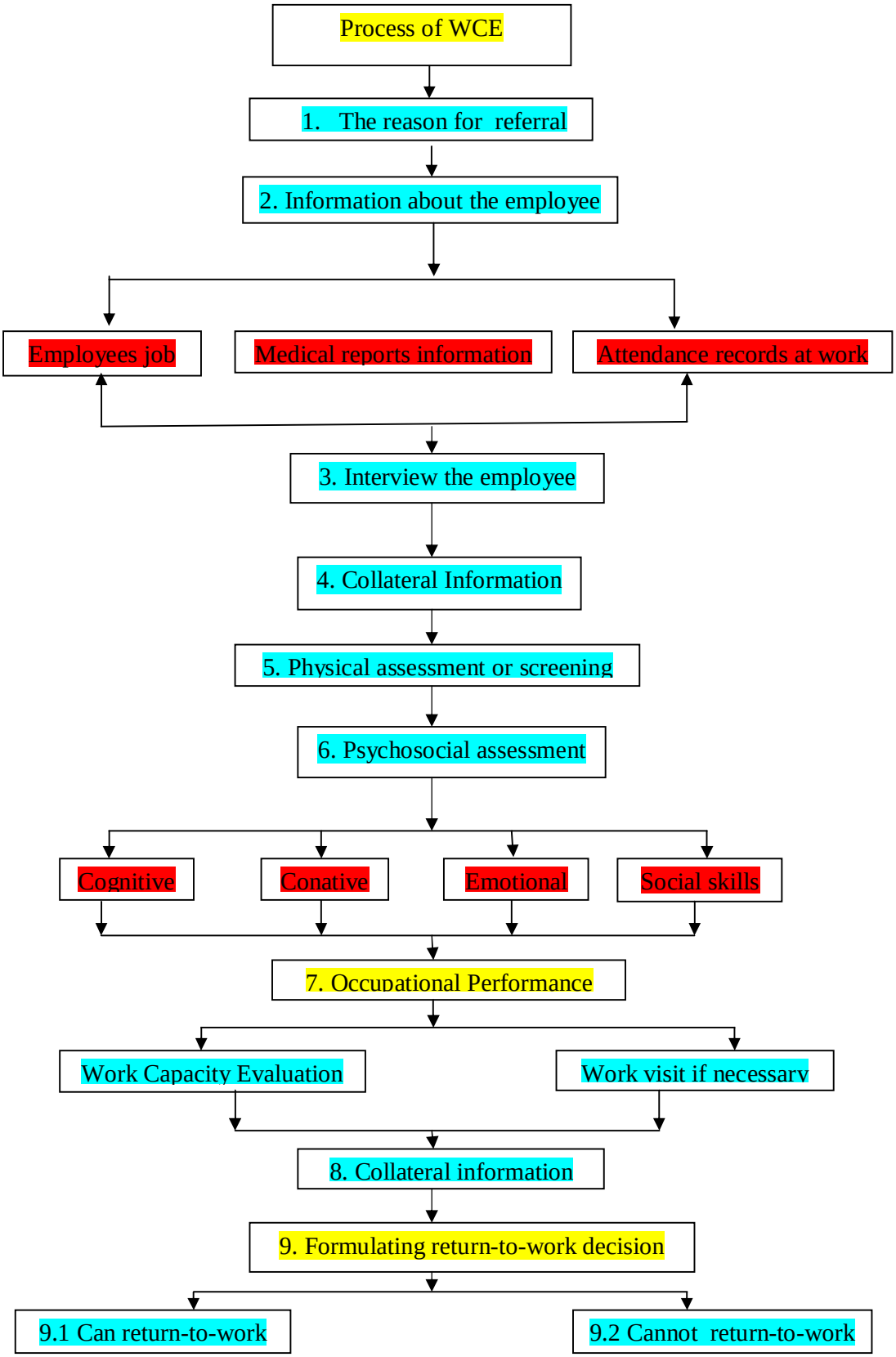

Diagram 2: The Process of WCE (n=9)

4.4.4 Theme 3: The competency requirements of the occupational therapist (to perform WCE)

For occupational therapists to perform quality WCE, they need to demonstrate some competency and perform their responsibilities within their scope of practice. The Canadian Model of Occupational Performance serves as a general guide to the profession and defines the scope of practice and the expertise and knowledge of occupational therapy practice[112]. It attempts to distil the assumptions, knowledge, values and beliefs commonly accepted throughout the profession[112]. The Triangular Model of Competency and Continuing Competency focuses on code of ethics (virtues of integrity, caring and prudence), analysis of job responsibilities and abilities (knowledge of critical reasoning, interpersonal skills, performance skills and ethical reasoning) and quality improvement (areas of expertise casually related to effective performance)[112]. Competency then ranges from being a novice to expert functioning.

i) Subtheme 1: Occupational therapist's knowledge

- **Phase one**

The following categories arose during phase one about the occupational therapistôs knowledge:

Table 4.21: Occupational therapist's knowledge in phase one (n=28)

Categories	Subcategories
Knowledge of pathology	Diagnosis of MDD, Personality disorders and prognosis
Knowledge of team members roles	Psychiatrists, EAP
Knowledge of the world of work	Know the employees job
Knowledge of current research and evidence practice	Knowledge of updated information and evidence about the pathology

- **Phase two**

The occupational therapistôs knowledge was not confirmed in phase two of the study. It came again during phase three of study. However, during phase three (focus group interview), it was cited as important by different participants, just as it had been in phase one.

- **Phase three**

Supporting reflections by the participants relating to "occupational therapists' knowledge" were:

- ⇨ ñYou [occupational therapist] need to be knowledgeable on the theoretical framework which includes the pathology [Axis1: Major depressive disorder, Axis 2: Personality disorders, Axis 3, Axis 4 and Malingering/Inconsistencies in behaviour]...ò
- ⇨ ñ...and the Model of Human Occupation (MOHO) by Kielhofner, the Model of Creative Ability by Vona du Toit, The Person-Environment-Occupational Model by Mary Law and basic vocational rehabilitation theory....ò
- ⇨ ñIf you [therapist] donôt have an idea of the MDD diagnosis... frame of references...you [therapist] will miss the point....ò
- ⇨ ñYou [therapist] need the knowledge of the process of work capacity evaluation...for possible steps to follow during work capacity evaluation...ò (refer to Diagram 2)
- ⇨ ñ...the basic knowledge of the world of work is also valuable... Legislation, the worldôs economic climate, the role of human resource practitioners, travelling methods to work...prevocational skills needed for MDD employees to return to work....ò
- ⇨ ñI [participant] sometimes have labour law issues... [and] will advise the client [employee]...or notify the referring agent about the clientôs [employeeôs] needs...ò
- ⇨ ñ...one has to learn about the world of work...you cannot sit in the medical model at this time...and hope you know...donôt be ignorant....ò
- ⇨ ñ...you [therapist] need to be quite clear about your [therapistôs] roles and boundaries...ò
- ⇨ ñIt will be wrong to exclude the knowledge of reasonable accommodation especially for psychiatric clients [employees]....ò

- **Phase four**

During member checking, Table 4.22 was shown to the participants and there were some additions from the participants which included The Person-Environment Occupation Model and OT Scope of practice.

Table 4.22: Occupational therapist's knowledge in phase three (n=11)

Categories	Subcategories
Knowledge of the pathology	• Diagnosis (MDD, Back pain) • Prognostic factors
Knowledge of the guiding theory	• MOHO by Kielhofner • Model of Creative Ability by vona du Toit • The Person-Environment-Occupation Model by Mary Law • Frame of references (Client centred, cognitive behavioural therapy) • Human physiology • Clinical/Professional reasoning • Vocational rehabilitation • OT Scope of practice
Occupational Therapy knowledge	• Assessment tools usage and interpretation • Intervention
Knowledge of the assessment process and Occupational therapy process	• Process of WCE • Identifying areas of occupation
Knowledge of the world of work	• Legislations • Unions • Human Resources Management • Performance appraisal systems • Industrial models • Reasonable accommodations • Economic climate
Knowledge of Ethical Values	• When does assessment/advice end • Costs involved • Honesty

Supporting reflections by the participants relating to "occupational therapists knowledge" were:

- ⇨ ñYou [therapist] need to be quite clear about your [therapist] own roles and boundaries [occupational therapy scope of practice]é .ò
- ⇨ ñ...sometimes you [therapist] just have to walk awayé .ò
- ⇨ ñ...cost must go up because you [therapist] make a decision on a personôs [employees] life...for the rest of their [employees] lifeé .ò
- ⇨ ñ... use [as therapist] other team membersô knowledge in the assessment...ò
- ⇨ ñ...when does the assessment end?ò
- ⇨ ñ...give assessment results....ò

Literature control: The occupational therapist knowledge base is derived from research and theories in occupational therapy, occupational science and disciplines beyond the field[112] such as psychology, kinesiology, psychiatry and research. Many occupational therapists are

not familiar with the use of evidence-based practice for the generation of scientific opinions based on standardised tests[158]. Most WCE administrators should be sufficiently grounded in science relating to WCE methods, case law and forensic analysis and principles based on reasoning and methodology that is scientifically valid[158]. Occupational therapists need to record and publish their experiences with regard to the use of WCE tools. Occupational therapists need to ensure that they are implementing the principles of evidence-based practice to ensure that resources are used most effectively[20]. It also means that secondary research is required to draw together the existing knowledge from different sources (whether empirical, theoretical or experiential evidence, for example) as the basis for future studies[162].

Thus, reflective practice will help the therapists to consciously analyse their decision making process in light of existing knowledge in order to generate new knowledge and ideas[15]. The value-shared knowledge amongst occupational therapists will augment existing knowledge and lead to improve quality of service in occupational therapy practices.

Occupational justice also describes the professionôs concern with ethical, moral and civic factors that can support or hinder health promoting engagement in occupations and participation in home and community life[20]. In Crepeau *et al.*[112], the code of ethics includes prudence, integrity and caring. The core values and attitude of occupational therapy practice include altruism, equality, freedom, justice, dignity, truth, and prudence[163].

> ñAccording to Principle 4 of the Occupational Therapy Code of Ethics (AOTA, 2005b), it is the duty of the occupational therapy practitioner to achieve and continually maintain high standards of competenceò[112] (p.245).

ii) Subtheme 2: Occupational therapists' experience

In this study, the occupational therapistôs experience was found to be valuable. This confirmed the observation by Jahn, Cupon and Steinbaugh[158] ñTesting is preferred over the battery approach, but requires an evaluator who is more experienced and is usually beyond most test battery administrators or therapistsò (p.3). The experienced occupational therapist is considered to be the best evaluator.

- **Phase one**

During phase one of this study, occupational therapistsô experiences were illustrated in Table 4.23.

Table 4.23: Occupational therapists' experiences in phase one (n=28)

Categories	Subcategories
Clinical experience	• Experience of the pathology • Experience of mental health
Life experience	• Cultural differences • Manipulative behaviour/Inappropriate illness behaviour

- **Phase three**

The subtheme of experience was not discussed in phase two. It reappeared during phase three (focus group interviews) of the study.

Supporting reflections by the participants relating to "occupational therapists' experience" were:

- ⇨ ñIf you [therapist] have worked before in a clinical setting with clients suffering from major depressive disorder...it is easier than someone [therapist] who is just doing vocational rehabilitation... or who has worked in the physical field....ò
- ⇨ ñIf you [therapist] donôt have an idea of the depressed client [employees]... you [therapist] will miss the point....ò
- ⇨ ñ...the older you [therapist] get, the more you [therapist] understand things [assessments and treatment] better...ò

- **Phase four**

During phase four, the following categories and subcategories in Table 4.24, were shown to the participants during member checking and were accepted.

Table 4.24: Occupational therapists' experiences in phase three (n=11)

Categories	Subcategories
Relevant clinical experience	• Worked in a psychiatric and vocational rehabilitation facility • General rehabilitation • Experience of the pathology (MDD)
Life experience	• Wisdom • Expert experience

Experiences that were considered valuable were given as clinical experience, rehabilitation experience and expert experience as an occupational therapist.

Literature control: In this study, the participants stressed the importance of a practitionerôs experience that it played a major role during WCE of employees suffering from MDD.

A study in Fawcet[15] suggest that structured reflection is the key to learning from experience. If the therapist has wisdom and expert experience, they will be able to show open-mindedness, flexibility and self-regulation.

iii) Subtheme 3: Occupational therapists' skill

It is important for qualified occupational therapists to continuously reflect on their practices in order to develop and improve their clinical skill[15].

- **Phase one**

During phase one, the following occupational therapistsôskills were categorised as shown in Table 4.25.

Table 4.25: Occupational Therapists' skills in phase one (n=28)

Categories	Subcategories
Therapeutic relationship skills	• Building rapport • Being patient
Interview skills	• Asking relevant questions
Clinical observation skills	
Problem solving skills	• Critical thinking • Analytical thinking
Administrative skills	• Good report writing skills

Categories	Subcategories
Research skills	• Developing practice models • Relating progress into context

- **Phase two**

During phase two, the occupational therapistsô skills in Table 4.25 were not included in the close-ended questionnaire for confirmation. The researcher enquired about the need for clinical reasoning during WCE and the response is captured in Figure XIX below.

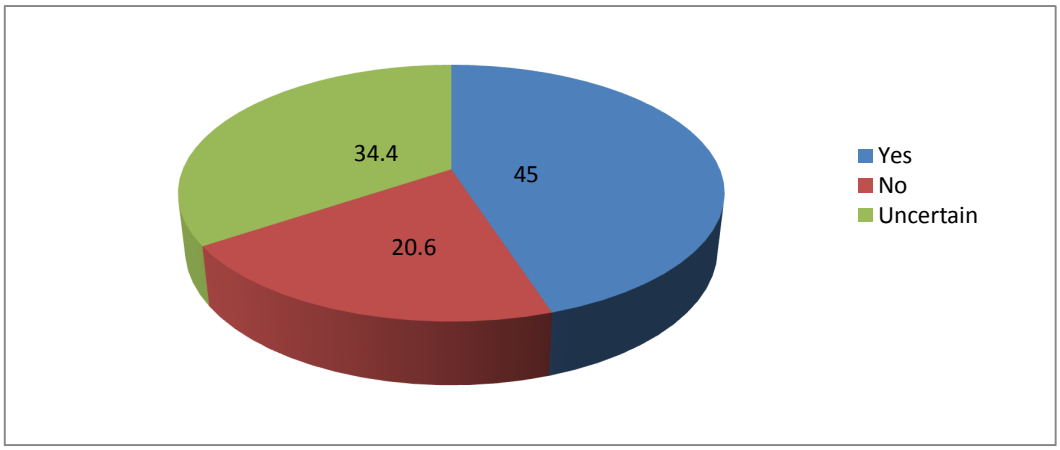

Figure XIX: Sufficient clinical reasoning skill in phase two (n=29)

During phase two, 13 (45%) participants thought it essential for the occupational therapist to have sufficient clinical reasoning skills while six (20.6%) participants reported that they did not regard such skills as necessary. Ten (34.4%) participants were uncertain owing to their ignorance about the theory and knowledge of clinical reasoning.

- **Phase three**

The importance of the occupational therapistôs skills came out again during data collection in phase three.

Supporting reflections by the participants relating to "occupational therapists' skills" were:

i) Administrative and management skills

- ⇨ ñYou [therapist] will need to have efficient administrative and management skills.ò
- ⇨ ñ...try to properly manage the time for assessment and report writing ...[and you also need] recording skills...good writing skills and proper record keeping skills...ò
- ⇨ ñYou [therapist] should keep reliable updated professional resources of rehabilitation centres...professionals and evidenceé .ò

ii) Negotiation skills

- ⇨ ñ...work capacity evaluation involves returning employees to worké .ò
- ⇨ ñYou [therapist] should have negotiation skillsé be able to negotiate with the client [employee]... employer and referring agent about returning the client to work....ò
- ⇨ ñWe [therapists] are the advocates of our clients [employees]....ò

iii) Observation skills

- ⇨ ñ...good observational skills are essential and important to observe the clientsô [employeesô] inconsistencies...performance during activity participation...ò
- ⇨ ñDonôt ignore to observe the clientôs level of motivation while executing the tasks....ò
- ⇨ ñDonôt assess and say goodbye...you [the therapist] need to think clearly about the client [employee]...including the qualitative components...I mean the observationsé .ò

iv) Therapeutic relationship skills

- ⇨ ñTherapists who are doing WCE are losing the idea of the therapist-patient relationship and they focus their duties towards the referring agent...ò
- ⇨ ñYou [therapist] need to build rapport with the clients [employees]...talk with the client [employee] and be warm and welcomingé .ò
- ⇨ ñ...judge the clientôs [employeeôs] temper...donôt come out too strong to them... you [therapist] need to be careful with depressed clients... always start at their level....ò
- ⇨ ñCreate boundaries while maintaining the therapist-patient relationshipé .ò
- ⇨ ñMaintain confidentiality at all times as the client [employee] shares some of the information since they [employees] trust you...ò
- ⇨ ñYou need to take the client into consideration...rather than the referring agents...ò

- **Phase four**

During member checking, the following occupational therapy skills in Table 4.26 were considered essential to perform Work Capacity Evaluation.

Table 4.26: Occupational therapists' skills in phase three (n=11)

Categories	Subcategories
Therapeutic relationship skills	• Build rapport • Therapist-patient relationship • Set boundaries • Confidentiality • Trusting relationship • Patience • Warm and welcoming • Reassurance • Respect the clientsô space
Clinical reasoning skills	• Diagnostic reasoning • Procedural reasoning • Interactive reasoning
Work Capacity Evaluation skills	• Interview skills • Observational skills • Use of standardised measurements/tools • Job analysis skills • Correlate qualitative and quantitative results • Formulate realistic recommendations
Negotiation skills	• Assertiveness skills • Diplomatic • Advocacy
Administrative and management skills	• Proper recording/ notes writing skills • Good report writing skills • Record keeping skills • Professionalism skills • Practice management skills
Case management skills	• Monitor progress • Follow up • Placement
Research	• Practice models • Evidence Based Practice

Literature control: The occupational therapist skills are divided into the interpersonal skills and practice skills[112]. In this study, the interpersonal skills include negotiation and management skills. Some of this echoed Lloyd[25] who writes that ñTherapists require the personal qualities of accurate empathy, non-possessive warmth and unconditional acceptance, and genuineness to establish a quality therapeutic relationship. This therapeutic relationship would in turn facilitate changeò (p.95) thus, therapists who perform WCE need to develop

therapeutic relationships with the employees who are seen for assessments. Such a relationship is dependent on a therapist having mastered enhanced leadership, administrative skills, communication competencies, negotiation skills and sometimes conflict-resolution skills[7].

Therapists also need to have efficient administrative and management skills to manage their time for WCE and report writing (recording skills, good writing skills and proper record keeping skills). This statement echoes the one in this study from one of the participants that

> ñIf you have worked before in the clinical setting with MDD employees, it is easier than someone who is just doing vocational rehabilitation or who has worked in the physical fieldò This shows how valuable it is to work with employees suffering from MDD prior to considering doing WCE. The skill of WCE that is developed over time or years is essential while working with MDD cases since ñThese proficiencies are often beyond those which are acquired during traditional graduate education courseòò[7] (p.199).

The literature highlighted the interpersonal skills such as communication skills and leadership skills, which were not mentioned in the study.

iv) Important factors to be taken into consideration by a competent occupational therapist

During this study, there were factors that were considered important for an occupational therapist to be called competent.

- **Phase one**

During phase one, there were important factors in Table 4.27 below that were suggested for a competent occupational therapist and these were confirmed in phase two as illustrated below.

- **Phase two**

Important factors were suggested in according to an occupational therapist to be labelled, competent as illustrated in Table 4.27.

Table 4.27: Important factors for "competent" occupational therapist in phase two (n=29)

Important factors for the competent therapist	Yes (%)	No (%)	Uncertain (%)
Make sure that you always verify information by getting/obtaining collateral information from treating specialists, family members and employers.	29 (100%)	0	0
Cross checking is very important to ensure that there is consistency during the interview replies, self report questionnaires, medical information, test results and the behaviour observed.	29 (100%)	0	0
It is important to note whether the clientôs response or symptoms are due to the depression or medication side effects.	29 (100%)	0	0
The stage of an illness either acute or chronic should be seriously taken into consideration during an FCE.	29 (100%)	0	0
FCE should always be performed on clients who are stabilised on treatment for minimum of 6 months or more	17 (58.6%)	6 (20.7%)	6 (20.7%)
Always think critically about the clientôs diagnosis and functional impairment. Be aware of the possibilities of misdiagnosis.	28 (96.5%)	1 (3.4%)	0
The phase in which the client is, i.e. pre or post admission or whether his/her condition is in remission.	29 (100%)	0	0
Always check for signs of heightened or depressed mood and the clientôs stress tolerance.	28 (96.5%)	0	1 (3.4%)
It is very important for the client to be able to handle symptoms such as frustration, lack of motivation, short temper, poor social interaction in such a way that the work capacity can be seen as separate to these problems.	19 (65.5%)	8 (27.6%)	2 (6.9%)
Look at interpersonal relationships at work, possibilities of promotions, demotions, disciplinary actions at work and other labour related issues.	29 (100%)	0	0
Most MDD employees are not motivated to work, so they may pretend to be very sick or incompetent in order to get their secondary gains. It is important to focus your assessment on their emotional status and vocational skills.	24 (82.7%)	0	5 (17.2%)
One should assess a client on more than one occasion to control the effect of good and bad days.	26 (89.6%)	2 (6.9)	1 (3.4%)
Do not be biased about the assessment results.	29 (100%)	0	0
Be as specific and practical as possible while writing the final report (make report simple and professional).	29 (100%)	0	0
Be consistent with the evaluation process and ensure that you cover all the performance areas.	29 (100%)	0	0
The therapist should ensure enough knowledge about the clientôs work([job description/job analysis) before	29 (100%)	0	0

Important factors for the competent therapist	Yes (%)	No (%)	Uncertain (%)
reaching a conclusion.			
Always discuss the importance of the assessment with the client	26 (89.6%)	1 (3.4%)	2 (6.9%)
Intermittent Jamar Dynamometer rapid exchange testing coupled with MODAPTS handwriting will assist to exclude malingering.	7 (24.1%)	7 (24.1%)	15 (51.7%)
The therapist should always check for consistency in effort and task execution.	29 (100%)	0	0
Always look at the clientôs level of creative ability during activity participation.	25 (86.2%)	0	4 (13.8%)

All the factors were accepted as they fell within consensus level of 55%, except intermittent Jamar Dynamometer rapid exchange testing coupled with MODAPTS sample for handwriting. These factors in Table 4.25 were not discussed during phase three and phase four of data collection.

Literature control: For Occupational therapists to provide credible and quality WCEs, they need to be competent. Anderson[164] aptly defines competency as ñthe ability of a professional to use knowledge, skills, attitudes, and judgement associated with a profession to practice with skill, efficiency, and safetyò (p.449).

Occupational therapy practitioners have perceived both formal and informal learning activities to affect continuing competency[164]. Therapist attributes were found to be related to positive alliance include conveying a sense of being trustworthy, experienced, honest, flexible, respectful, confident, interested, alert, friendly, warm and open. A stronger alliance improves outcome[25]. Unless individual occupational therapists feel professionally competent and have a clear understanding of the philosophy and principles underpinning their professional practice in mental health, they will not be able to handle role confusion and conflict amongst the team members[82].

The above information indicates that the competency requirements of an occupational therapist include the practice where occupational therapy will take place and the qualities of the therapist. Diagram 3 below illustrates the competency requirements of an occupational therapist, focusing on the practice and the desirable qualities of an occupational therapist who administer WCE with employees suffering from MDD.

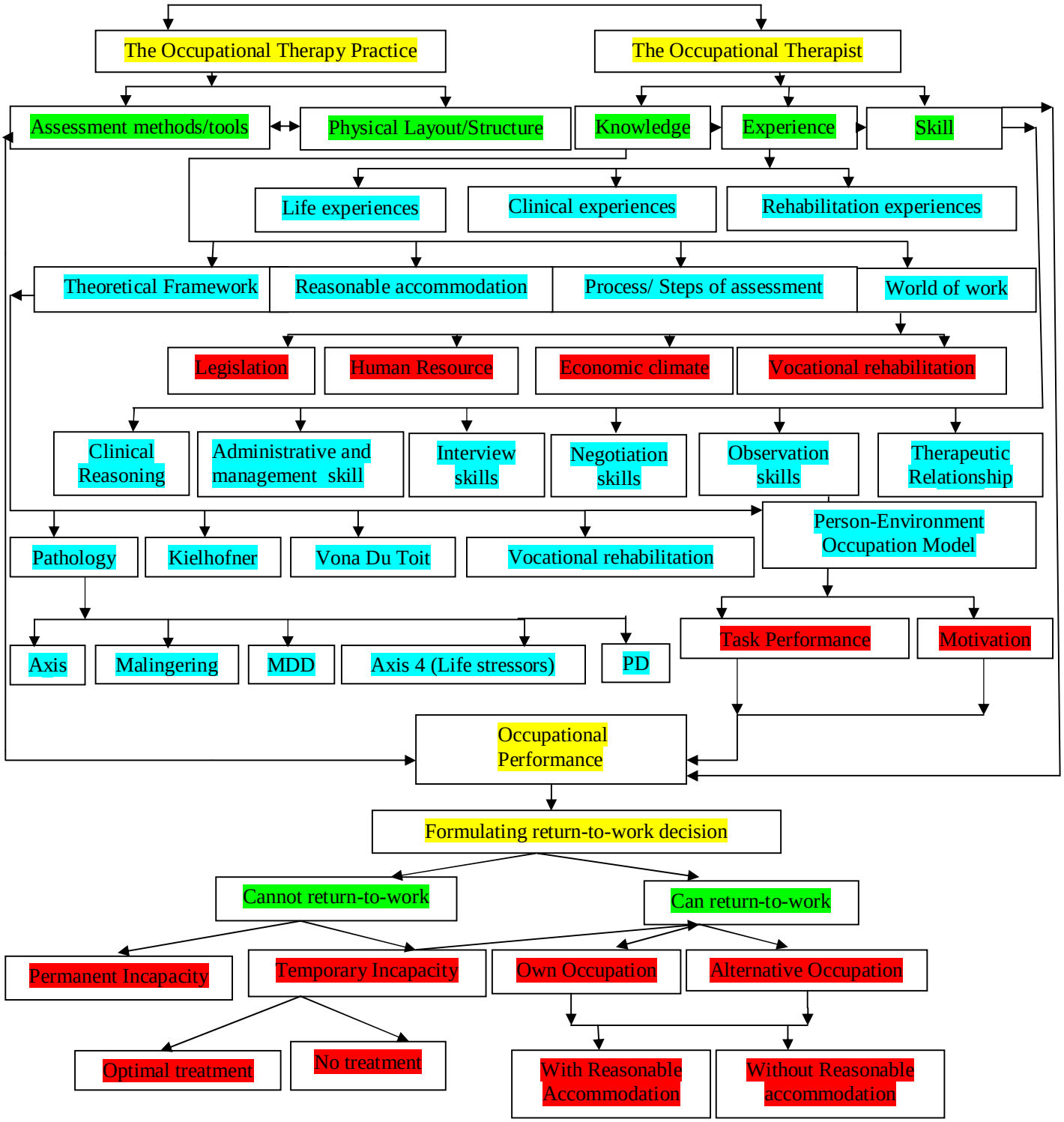

Diagram 3: Requirements to perform WCE (n=9)

4.4.5 Theme 4: Occupational performance

Occupational performance is the accomplishment of the selected activity or occupation resulting from the dynamic transaction among the client, the context, and the activity[56]. Performance skills such as sensori-motor, cognitive, psychosocial, and psychological skills and abilities are the elements of functional performance, which occupational therapists have expertise to assess and intervene for improved performance [1,3,20]. The areas of occupation are life tasks such as activities of daily living, work, and play or leisure[1,3,20].

The following performance skills and areas of occupation were identified during data analysis of this study.

i) Subtheme 1: Performance skills

Performance skills are associated with the symptoms of depression.

- **Phase one**

During phase one of the study, the following performance skills in Table 4.28 were identified:

Table 4.28: Performance skills in phase one (n=28)

Performance skills	Frequency of participants	Percentage of responses
Motivation	9	32.1%
Cognition (insight, concentration, memory, problem solving skill)	6	21.4%
Emotions (depressed mood, blunted affect, low self-esteem)	4	14.3%
Conation (Psychomotor retardation)	6	21.4%
Perseverance	4	14.3%
Psychological endurance	4	14.3%

In this study, motivation was found to be the most affected performance skill amongst employees suffering from MDD. It was followed by cognition and psychomotor activity (conation) and emotional state.

- **Phase two**

During phase two, the performance skills were confirmed as follows in Figure XX.

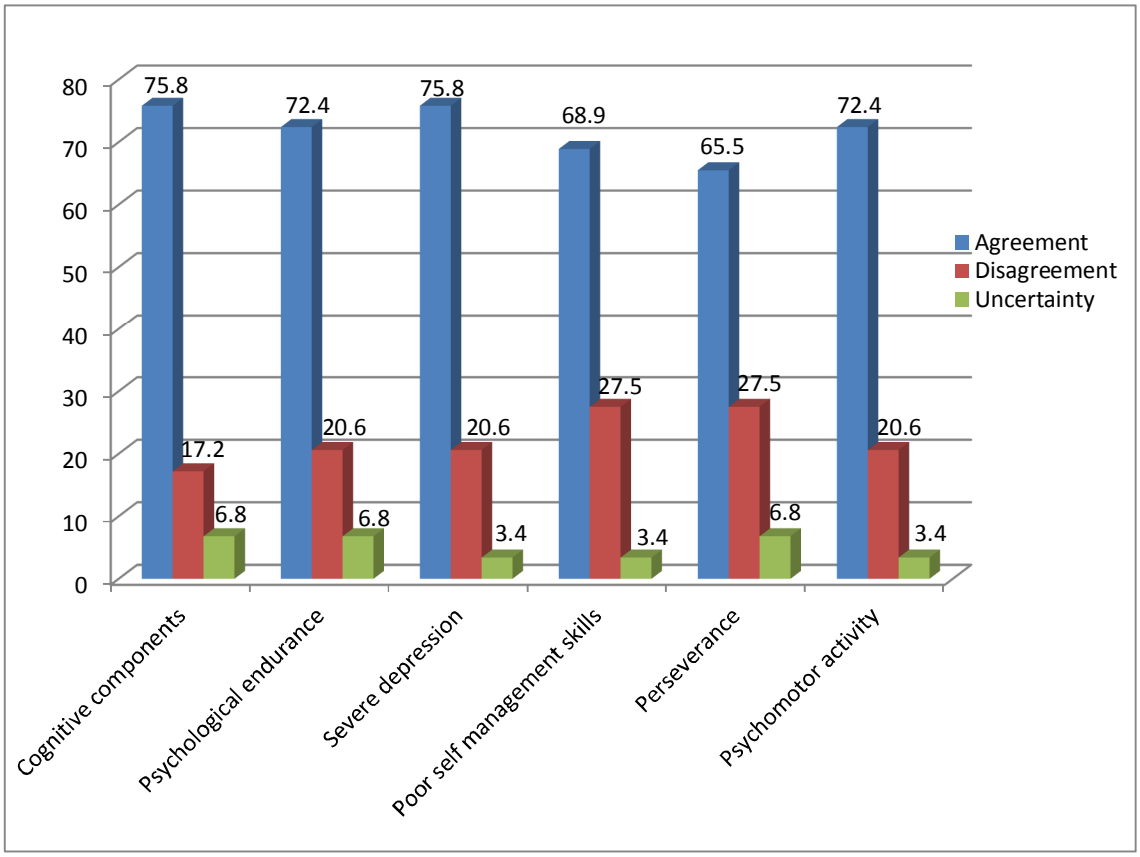

Figure XX: Performance skills that affect work capacity in phase two (n=29)

In Figure XVI, it was suggested that performing a comprehensive psychiatric evaluation as stated in DSM-IV-TR[28] that includes cognitive skills (thought process, memory, concentration, decision making), mood and affect and psychomotor activity is essential.

In this study, the following performance skills were considered important while assessing an employee with MDD: cognitive components such as poor concentration, poor insight, poor memory (forgetfulness), poor problem solving skills and difficulty following instructions, emotional state such as severe depression, psychomotor activity such as psychomotor retardation and psychomotor agitation, psychological endurance and poor self-management skills, which included coping skills, stress tolerance in a workplace and coping skills despite training and support and perseverance. When an occupational therapist is performing WCE

on employees suffering from MDD, the performance skills mentioned above will need to be assessed.

- **Phase three**

Supporting reflections by the participant relating to "performance skills" were:

- ⇨ ñIt depends on the clientôs [employeeôs] drive, motivation, insight and performanceé .ò
- ⇨ ñ...people who have been off work, their motivation is mostly affected....ò
- ⇨ ñ...check if the person [employee] has insight to their condition...that goes with stigma associated with MDD....ò
- ⇨ ñYou [therapist] can physically see...depressed clients have low energy....ò
- ⇨ ñ...the cognitive aspects have a major impact....ò
- ⇨ ñ...another important factor to consider to check is the coping skills...what coping skills do they implementing them?ò
- ⇨ ñYou will pick up vegetative signs...sleep...appetite...sexual drive....ò
- ⇨ ñ...ask the open-ended question...check the memory if they [employees] are forgetting the details...ò
- ⇨ ñI think what we [therapists] are touching is psychomotor activity...you [therapist] can walk with the client [employee] if that is part of their job...observe psychomotor agitation or retardation....ò
- ⇨ ñ...donôt [therapist] exclude the frustration tolerance level of the client [employee]....ò

- **Phase four**

During phase four, the following performance skills were emphasized as illustrated in Table 4.29 below:

Table 4.29: Performance skill (n=9)

Subtheme	Categories
Performance skill`	• Concentration • Psychological endurance • Perseverance • Physical endurance • Psychomotor activity • Coping with failure • Handling criticism • Frustration tolerance

Literature control: Depressive symptoms affect an individualôs drive and energy to work, ability to concentrate on work tasks, undermines personal confidence and self-esteem at work[25,165]. Other studies report that depression may impair cognitive functioning, which in turn decreases sustained concentration, anhedonia and similar depressive symptoms may act to decrease motivation to sustain effort on tasks, while negative thoughts and beliefs that accompany depression may increase negative thoughts about pain. There are instruments that measure the overall symptom profile of depression as well as its cognitive, behavioural, and mood components, life events; and the underlying cognitive diathesis[26,27,28]. It is also useful to assess a depressed patientôs strength and resources[27].

Combined, these symptoms may decrease beliefs that one can successfully perform certain tasks[4]. These symptoms may further affect the clientôs ability to cope with daily life tasks.

Cognitive functioning was found to be a significant predictor of good employment outcome[10]. In one study, cognitive impairments presenting in mental illness have been associated with personal insight, attention and concentration, working memory, processing speed, psychomotor speed and executive functioning that are fundamental to the task and social demands of contemporary work settings[25]. According to Sadock and Sadock[28] ñcognitive symptoms include subjective reports of an inability to concentrate (84% of patients in one study) and impairment in thinking (67% of patients in another study)ò (p.554).

Sadock and Sadock[28], Crouch and Alers[165] and Lloyd[25], agree with the findings of this study shown in Table 4.29 and Fig XX that cognitive symptoms such as attention and concentration, insight, memory and problem-solving skills affect the employees work capacity.

ii) Subtheme 2: Areas of occupation

The ability to carry out activities of daily life includes activities in the areas of occupation: Activities of Daily Living[3,7,20, 55] (Basic Activities of Daily Living and Personal Activities of Daily Living), Instrumental Activities of Daily Living, education, work, play, leisure, and social participation.

- **Phase one**

During phase one of this study, the following areas of occupation in Table 4.30 were illustrated as follows:

Table 4.30: Areas of occupation in phase one (n=28)

Areas of occupation	Number of participants	Percentage of participants
Personal management (sleeping patterns)	15	51.7%
Socialisation (social withdrawal)	12	42.9%
Poor work skills (work motivation, work habits, work speed, work endurance, work productivity)	23	82.1%
Use of leisure time	0	0

None of the participants mentioned the use of leisure time. Most of the comments were in the area of work skills (pre-vocational and vocational skills) by 23(82.1%) participants.

- **Phase two**

Areas of occupation in Table 4.30 were confirmed in Figure XXI. The important areas of occupation were cited as work habits, work endurance, work productivity, poor work motivation, social skills, work speed, interpersonal skills and home management.

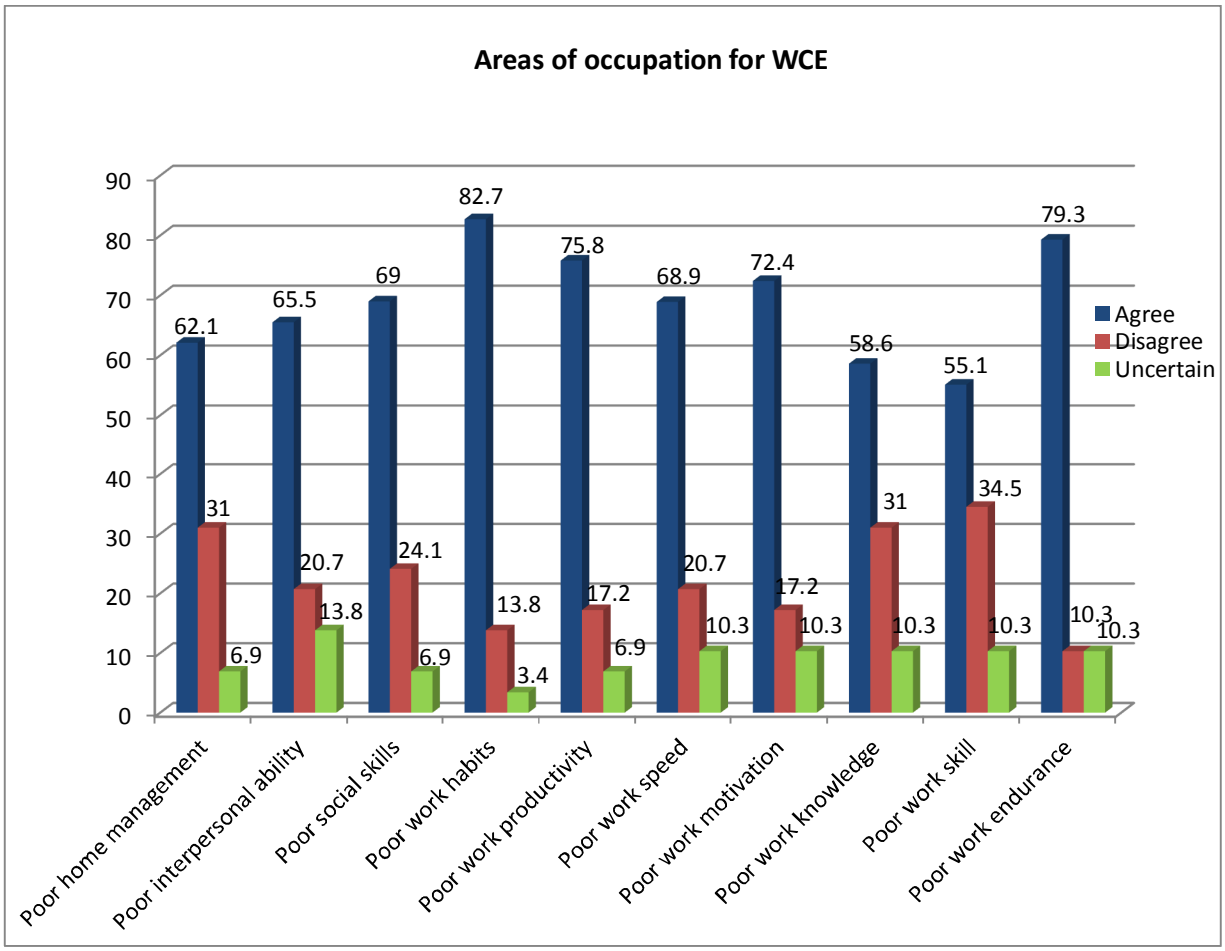

Figure XXI: Areas of occupation that affect work capacity (n=29)

- **Phase three**

Supporting reflections by the participants relating to "areas of occupation" were:

- ñ...performance over time [pre-morbid functioning] will give you [therapist] a far better idea than a performance on that day [day of assessment]é .ò
- ñ...clientôs [employeeôs] presentation of the work abilities today...could be different tomorrow...could be different next weeké .ò
- ñIt is complicated [assessment of employees with MDD]...it is different from physical assessment...lot of factors have an influence in their [employees] functioning....ò
- ñIf they [employees] canôt cope with their immediate life responsibilities... and their life roles...they [employees] wonôt be able to cope at work...ò
- ñ...maybe like comprehensive evaluation of all aspects of that personôs [employeeôs]

life...if we talk of OT [occupational therapy]...work...ADL [activities of daily living]...social...I mean, general functional ability....ò

- ⇨ ñYou [therapist] are damn right...it is actually the sole role of OT ...general functional ability....ò
- ⇨ ñ...actually thatôs what differentiates us [occupational therapists]...we are functional experts...do [assess] a clinical functional assessmenté .ò
- ⇨ ñ...is it functional occupational performance with the knowledge of work and depression?ò
- ⇨ ñ...assess the social functioning in a group setting....ò
- ⇨ ñ...what are the social expectations of the person [employee] when they return to work?ò

- **Phase four**

During phase four, the areas of occupation that were confirmed and accepted are illustrated in Table 4.31 below:

Table 4.31: Areas of occupation (n=9)

Subtheme	Categories
Areas of occupation	• Activities of daily living (self care, functioning at home, medication side effect) • Social functioning • Work (prognostic factors, daily activity profile, work competency, coping with responsibilities and roles, norm compliancy at work, work endurance)

Literature control: Areas of occupation involve our day to day activities such as activity of daily living, work, leisure and socialisation. For a person to be considered mentally healthy, they should be able to cope well with all the areas of occupation. Functional limitations that are caused by psychosocial disabilities vary from different individuals to individuals and depends upon the diagnosis, chronicity of the condition, medication being used, social, environmental and personal factors[10]. These functional limitations are common amongst employees suffering from MDD. Major depressive patients struggle to perform simple daily tasks such as work, play, friends and family[165]. Depressed patients show an inability to perform even the simplest daily tasks. Work, play, friends and family are all neglected[165].

Performance components such as cognitive impairment may also impact areas of occupation such as social skills and employment. In Fig XXI, social skills were found to impact on the employeeôs interpersonal relationship at work.

The particular work productivity patterns that have been associated with depression include presenteeism[25]. Studies have found that depression can negatively impact focus on work tasks, and create difficulties with mental-interpersonal tasks, time management and output tasks[10,25]. Other studies cited in Lloyd[25] showed that occupations with high demands for decision-making, communication and frequent interpersonal contacts with the public were particularly associated with loss of productivity in depression.

The following occupational performance should be included in the vocational evaluation of people with psychosocial disabilities: work motivation (intrinsic and extrinsic), work endurance (activity profile, psychological endurance, nature of side effects), basic work habits (attendance, communication skills, conflict resolution skills), work task (error correction, task concept, use of material and tools), work skills and knowledge and productivity (work speed, quality output, productivity under pressure)[10].

4.4.6 Theme 5: Formulating return-to-work decision

Work is considered to be valuable in a personsô life. Major depressive disorder affects the employees ability to work. Occupational therapists have a key role to play in facilitating safe, effective and timely return-to-work, particularly since returning to work is hailed as an important part of an employeeôs recovery[7].

The following subtheme emerged during phase three with regard to facilitating a return-to-work decision: the employeeôs biographical profile, the employerôs point of view, the employeeôs point of view, the therapistôs decision to return-to-work, declaring the employee as temporarily incapacitated, declaring the employee as permanently incapacitated and determinants of the employeeôs level of motivation.

During phase one and phase two of the study, there were no data obtained that related to return-to-work decision. The theme on return-to-work decision appeared very strongly during

phase three and phase four of data collection. The findings will be illustrated using subthemes as they emerged in phase three of the study.

i) Subtheme 1: The "employee's biographical profile" on return-to-work decision

- **Phase three**

Supporting reflection by participant relating to "the employee's biographical profile" were:

⇨ ñ...clientôs [employeeôs] age and gender have an effect in returning them to work...ò

- **Phase four**

Participants agreed that age and gender have an effect in formulating return-to-work decisions.

Literature control: The clientôs age is a predictor and has an impact on returning to work[25,166]. Socio-demographic variables such as gender and age are important factors for the ability to return-to-work[166]. A normative data base segregated by age, gender, and vocation (blue collar vs white collar) were found to be reliable when tests were carried out[157]. The personôs profession is another important factor for the ability to return-to-work[166]. Gender is the strongest predictor of return-to-work[4]. Women tend to have more sickness absence than men, and some differences in the relation between psychosocial work environment and sickness absence by sex have been found[31]. Being male and being young, were predictors of RTW among those who are sick since men returned-to-work earlier after a certified sick leave than women[166].

The literature agrees with the findings of this study on age and gender as biographical predictors on return-to-work decision with an addition from literature on vocation (type of job).

ii) Subtheme 2: The "employer's perspective" on formulating return-to-work decision

- **Phase three**

Supporting reflections by the participant relating to "the employer's point of view" on return to work decision were:

- ⇨ ñ...it is problematic to return the client [employee] to work when the workplace is blocking [hampers returning to work]é .ò
- ⇨ ñ...find out if there are issues of constructive dismissal....ò
- ⇨ ñ...when the working environment is making the situation intolerable...the person [employee] canôt get back to that job...ò
- ⇨ ñ...employer is the judge of reasonable accommodations and you [therapist] will need to negotiate with the employer...ò
- ⇨ ñ...the therapist needs to look at how the employees with MDD are functioning at work and the possibility of reasonable accommodations if they return to work...ò

- **Phase four**

The following categories in Table 4.32 were accepted during phase four of data collection as the employerôs point of view in formulating return-to-work decision.

Table 4.32: Employers point of view to formulate return-to-work decision (n=9)

Subtheme	Categories
Employer's point of view	• Employeeôs past work history and poor work records • Blocking workplace • Constructive dismissal • Employerôs ignorance • Unwillingness to reasonably accommodate

Literature control: Ross[7] pointed out that employers have a major role to play during the return-to-work process of ensuring that people with disabilities are not discriminated against during recruitment and selection process[7]. Workplace characteristics such as the stigma associated with mental illness, the lack of accommodations, and labour market characteristics

are the central barriers to employment among persons with mental illness[7,67]. Research suggests that there may be four types of barriers to employment among individuals with mental illness: (a) illness characteristics; (b) client characteristics; (c) access to service and appropriate mental health treatment; and (d) characteristics of the workplace and the labour market[67].

The employer places a major role in ensuring that the sick employee returns to work. ñA successful return-to-work is unlikely to be achieved without the cooperation and goodwill of the employerò[7](p.131). If the work environment is hostile, it is a barrier to a successful return-to-work[7]. A worker who is always absent often places a significant financial burden on a company, as well as additional work pressure on co-workers[7]. ñFrom an employerôs perspective, absence from work may result in lost production, disruption, a decrease in efficiency, missed opportunities and reduced quality of service, all of which have a negative effect on the competitiveness and profitability of any businessò[7](p.48). This shows that it is important to facilitate an early return-to-work as soon as possible.

iii) Subtheme 3: The employee's point of view on return-to-work decision

- **Phase three**

Supporting reflections by the participant relating to "employee's point of view" on formulating return to work decisions were:

- ⇨ ñ...it is difficult to return the client [employee] to work when they [employee] fear returning to work.ò
- ⇨ ñ...assess the clientôs [employees] job seeking skill...ò
- ⇨ ñ...ensure that the employee can keep up with the job.ò

- **Phase four**

The categories in Table 4.33 were accepted during phase four of member checking as illustrated.

Table 4.33: Employee's point of view on return-to-work decision (n=9)

Subtheme	Categories
Employee's point of view	• Fear of returning to work • Secondary gains • Stigma • Lack of work skill • Poor work motivation

Literature control: Refer to the literature control in last subsection.

iv) Subtheme 4: "The therapist's perspective" on return-to-work decision

- **Phase three**

Supporting reflections by participants relating to "the therapist's point of view on formulating return-to-work decisions" were:

- ⇨ ñ...when the client [employee] starts to complain about deterioration in physical endurance during the day, you [therapist] should consider Axis 3 diagnosis...ò
- ⇨ ñ...comprehensive assessment is important because client [employee] will not return to work unless the therapist really addresses and manages their medical problems.ò
- ⇨ ñ...look [therapist] at the time capacity that they [employees] have been outside the workplace...ò
- ⇨ ñ...if they [employees] canôt cope with immediate life responsibilities and life roles, they wonôt be able to cope at work...ò
- ⇨ ñ...is the working environment conducive to return them [employees] early to work?ò
- ⇨ ñ...you [therapist] must make some attempts to return the person to work...then you [therapist] will see if it is working or not...ò
- ⇨ ñ...match the client [employee] with the work...before you [therapist] can even return the client [employee] to work...you [therapist] need to know what to expect from work?ò
- ⇨ ñ...be sure that the client [employee] can keep up with the job...ò
- ⇨ ñ...we [therapists] need to consider the potential for re-skilling...ò

- **Phase four**

During phase four, Diagram 4, illustrates the factors relating to the medical decision on formulating return-to-work decision was discussed with the participants. The participants endorsed Diagram 4 as illustrated.

a) Medical decision

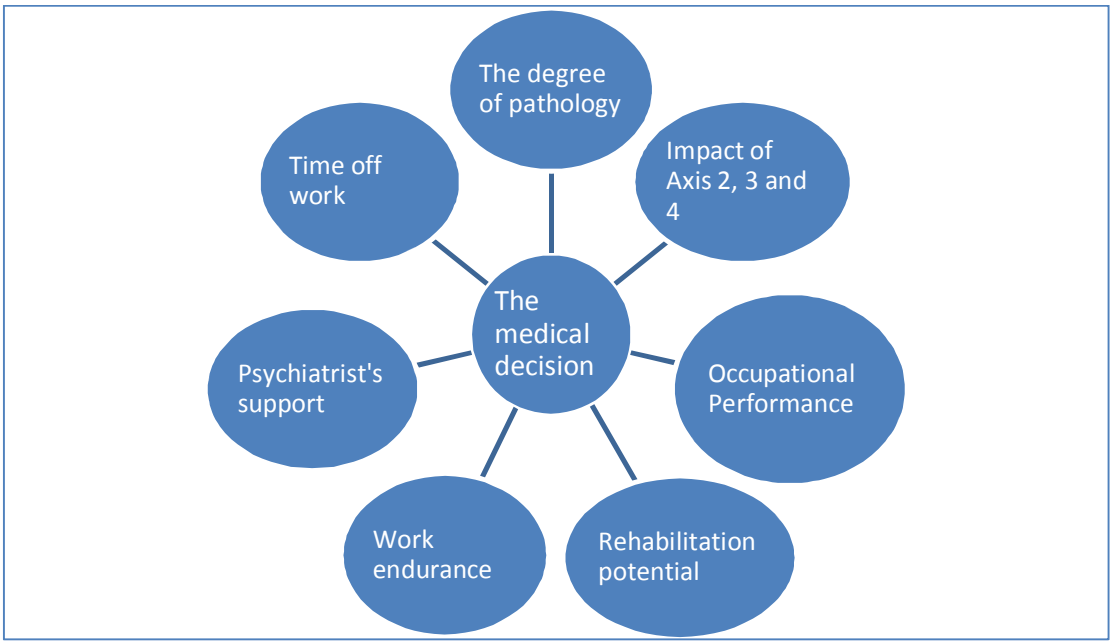

Diagram 4: Medical decision of formulating return-to-work (n=9)

The medical decision highlighted factors such as the degree of pathology, impact of Axis 2,3, and 4, occupational performances affected, possibilities of rehabilitation potential, employeeôs work endurance (stamina), psychiatristôs support and the time off work.

b) Psychosocial decision

Diagram 5, illustrates the factors relating to the psychosocial decision on formulating a return-to-work decision as discussed with the participants. The participants endorsed Diagram 5 as illustrated.

Diagram 5: Psychosocial decision of formulating return-to-work (n=9)

The psychosocial decision highlighted factors such as social expectations at work, impact of interpersonal relationships at work, good support system at work, home or from health team, any previous attempts to return to work, any available programs to prepare the employee to return to work, employeeôs potential for reskilling or transferable skills, unsuccessful work trials and investigating the job and the work environment.

Literature control: Occupational therapists who perform WCE have to make a major decision with regard to the employeeôs safe, effective and timely return-to-work[7]. There is no hard and fast rule on making the decision of returning the employee to work as it depends on a variety of factors[7]. Ross[7] highlighted some key factors that influence the decision of returning to work which are compared to the findings of this study:

Table 4.34: Factors to determine return-to-work decision

Factors that influence return to work decisions Ross[7] (p.130)	Study Findings in diagram 4 and 5
1.Motivation to return-to-work.	Employeeôs motivation to return-to-work. Employeeôs fear of returning to work.
2.Level of job satisfaction with their job.	Lack of skill. Good support system at work/home/team.
3.Occupational and worker identity.	Any attempt of returning-to-work.
4.The clientsô pre-injury/illness relationship with others at work.	Employee work history.

Factors that influence return to work decisions Ross[7] (p.130)	Study Findings in diagram 4 and 5
5.The nature of the clientôs condition and their experience of illness.	The degree of pathology. Impact of Axis 2, 3, and 4. Rehabilitation potential. Potential for re-skilling and transferable skills.
6.The stage and pace of the clientôs recovery.	Prognostic factors. Programs of preparing to return the employee to work. Work trials.
7.Ongoing complications such as pain and fatigue.	Poor work endurance.
8.The length of time the client has been away from the workplace.	Time off work. Blocking workplace.
9.The demands and requirements of the clientôs job.	Investigate the job and the environmental demands. Social expectations at work.
10.The nature of any identified risks.	Impact of interpersonal relationship at work.
11.The clientôs age.	Employeeôs biographical profile that includes age and gender.
12.The clientôs existing financial commitments.	Secondary gains.
13.Involvement in a legal process.	Poor work records. Possibilities of constructive dismissal.
14.Whether the clientôs condition is covered by the disability Discrimination Act.	Employerôs ignorance. Employerôs unwillingness to reasonably accommodate the employee.

Lloyd[25] does not mention the significance of the clientôs [employeeôs] gender. In this study it emerged as crucial to a return-to-work decision.

Table 4.32 highlights issues of constructive dismissal, in a manner that validates Lloydôs[25] conclusion that involvement in a legal process may impact the return-to-work decision. Other suitable rehabilitative services include job modification, workplace modification, case management and provision of workplace aids and equipment[103]. Some researches cited in Millward *et al.*[29] maintains that those who do return-to-work successfully following a long-term period of depression-induced absence, mostly always do so in a different capacity, and for some this will denote complete change of career. Other studies reported that time off work or longer period of sick leave makes return-to-work more difficult and requires more resources[4,166,167]. The number of sick days before rehabilitation and age were strong predictors of RTW. Self-rated pain, life events, gender, physical capacity, self-rated functional capacity, educational level and light physical labour were also predictors of RTW in the long term[166].

v) Subtheme 5: Declaring employee as temporarily incapacitated

- **Phase one**

During phase one, the following factors in Table 4.35 were suggested as the common causes of temporary incapacity.

Table 4.35: Factors to determine employee's incapacity to work in phase one (n=28)

Factors to determine employee's incapacity	Frequency of participants	Percentage
Background information: • Poor support system at home • Poor support system at work • Employeeôs level of education	3	10.7
Medical information: • Treatment compliancy • Control of symptoms • Side effects of medication • Length of hospitalisation • Number of hospitalisation sessions • Psychotic features	10	35.7
Performance skills: • Severe depression • Emotional instability • Irritability • Poor psychological endurance • Poor level of motivation • Hypoactive/psychomotor retardation • Cognitive impairment (poor concentration, poor frustration tolerance) • Suicidal ideas	28	100%
Areas of occupation: • Difficulty to cope with ADL • Difficulty to cope with home management tasks • Poor work motivation • Poor work habits (High absenteeism, poor task accuracy, inability to recognise and correct errors, inability to sustain effort, poor task completion) • Poor work speed and accuracy • Reduced productivity level • Poor work endurance (physical and cognitive)	26	92.9%
Work environment: • Employerôs unwillingness to accommodate employee • Socio-political issues in a workplace	6	21.4%

- **Phase two**

These aspects in Figure XXII result employeeôs temporary incapacity to work.

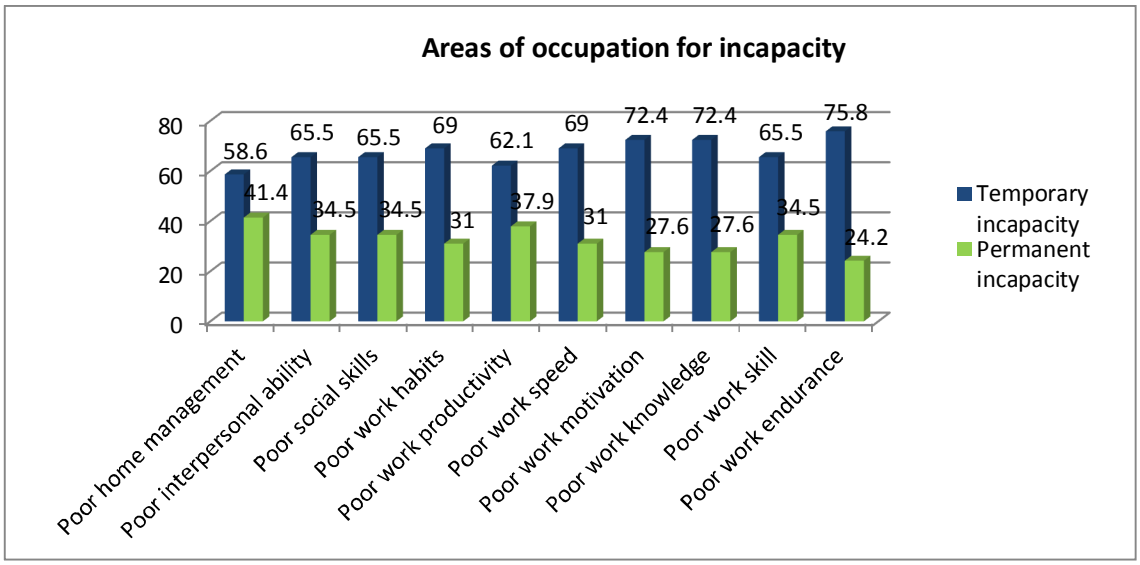

Figure XXII: Areas of Occupation for incapacity to work in phase two (n=29)

The following areas of occupation in Figure XXII, were found to have a major impact in determining the employeeôs temporary incapacity to work: struggling to carry daily tasks at home, poor interpersonal skills, poor social skills, poor work habits, poor work productivity, poor work speed, poor work motivation, poor work endurance, poor work knowledge and poor work skills.

Long history of depression in Figure XXIII results in the employeeôs incapacity to work. The employees with a history of depression for more than two years will be incapacitated to work due to their frequent relapses despite compliancy to treatment, unresponsiveness to team intervention, depressive symptoms persisting for more than two years, psychotic features and high risk of suicide.

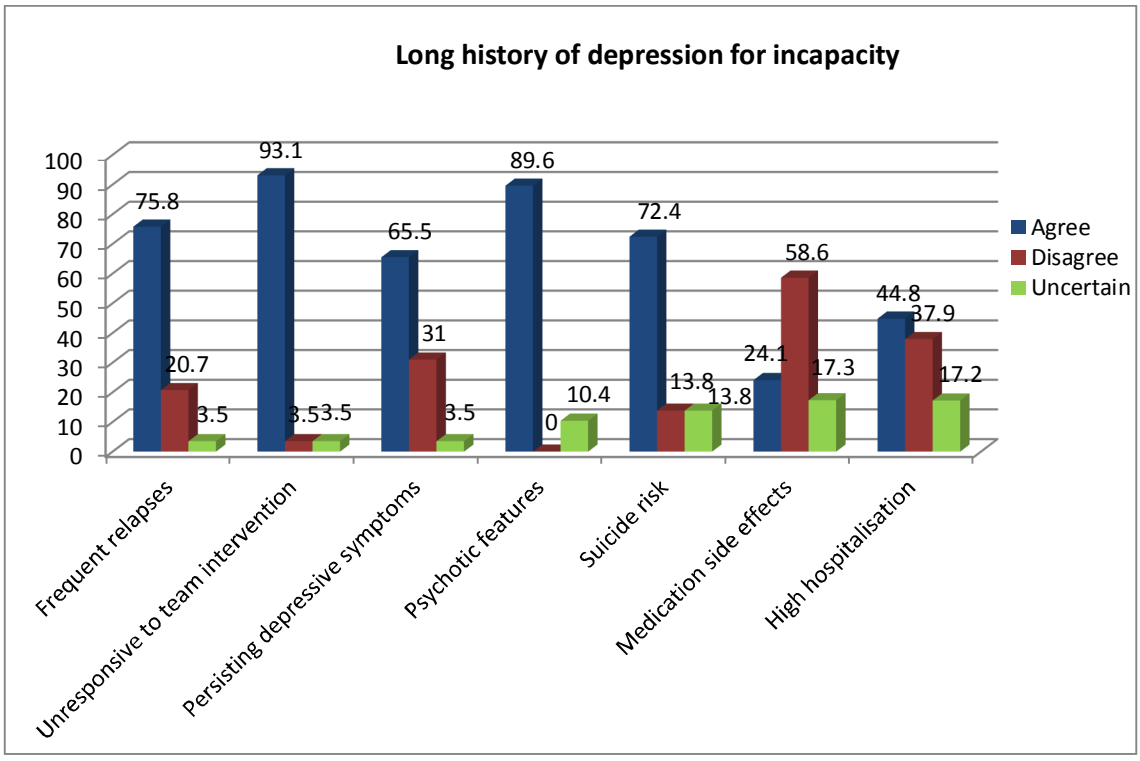

Figure XXIII: Long history of depression in phase two (n=29)

The researcher went further to determine whether a history of depression determines temporary or permanent incapacity as shown in Figure XXIV.

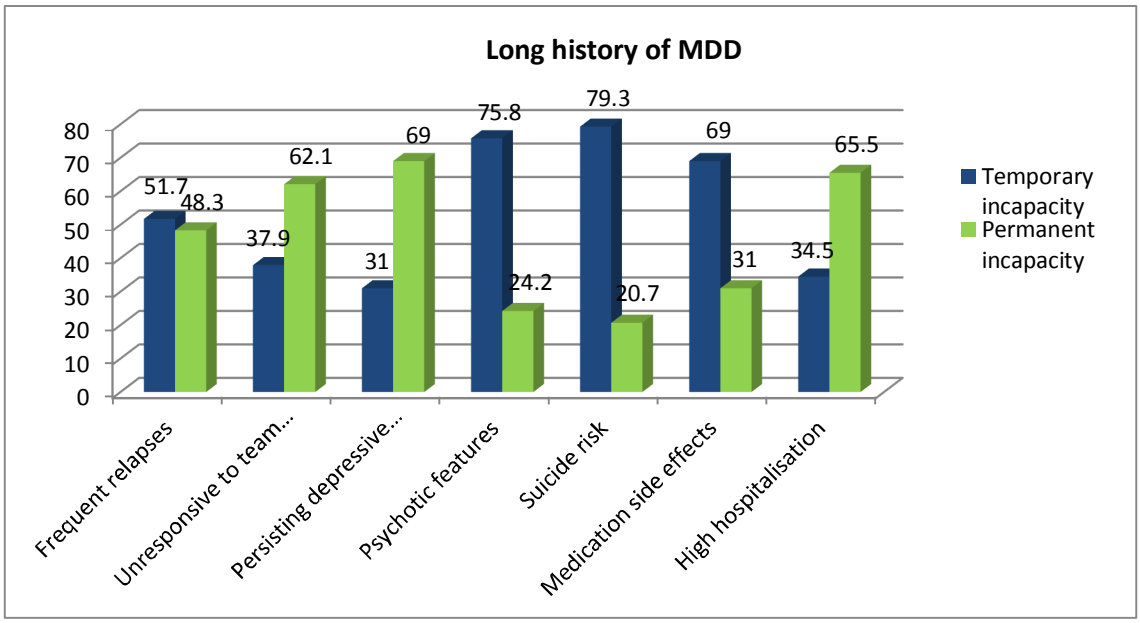

Figure XXIV: Incapacity determinants in phase two due to long history of depression (n=29)

As illustrated in Figure XXIV, to determine temporary incapacity employees with MDD should present with psychotic features, suicide risk and medication side effect.

The performance skills in Figure XXV, were found to have an influence in determining the employeeôs incapacity to work.

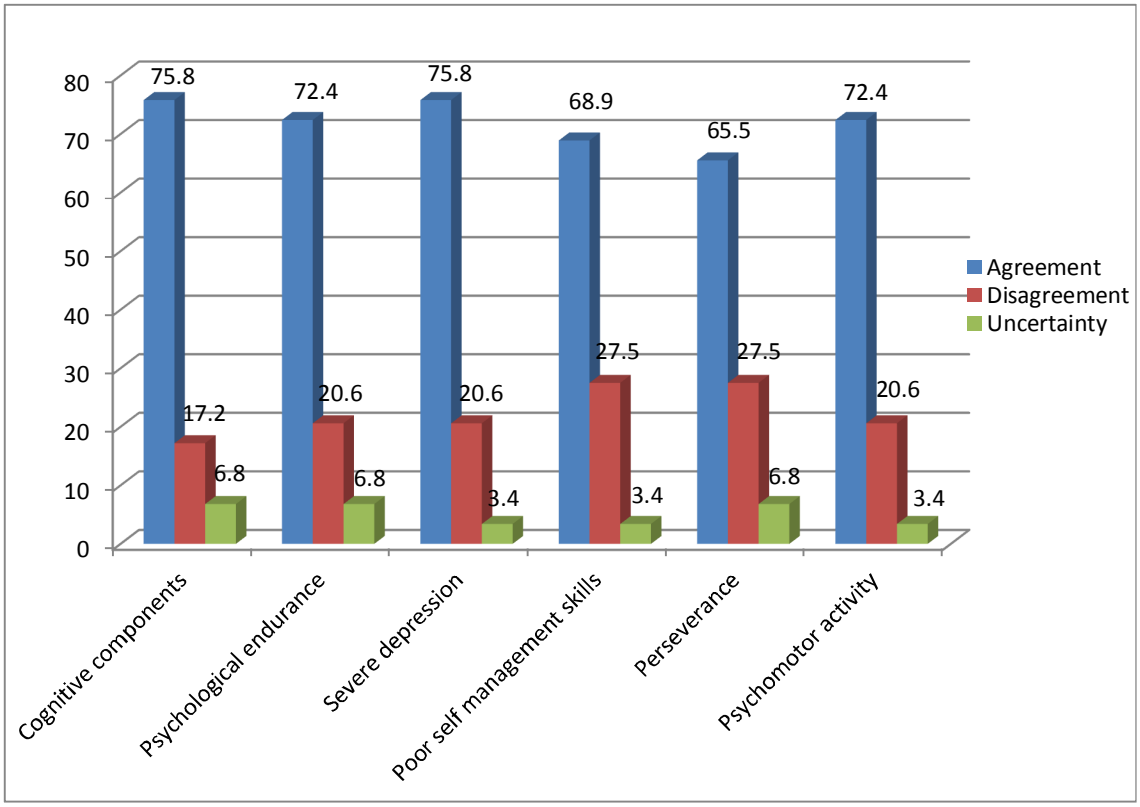

Figure XXV: Performance skills affecting capacity to work in phase two (n=29)

The performance skills that needed to be assessed to determine the employeeôs incapacity to work are cognitive components, psychological endurance, severity of depression (severe low mood), self-management skills, perseverance and psychomotor activity.

The following symptoms in Figure XXVI were found to be helpful in determining the employeeôs incapacity.

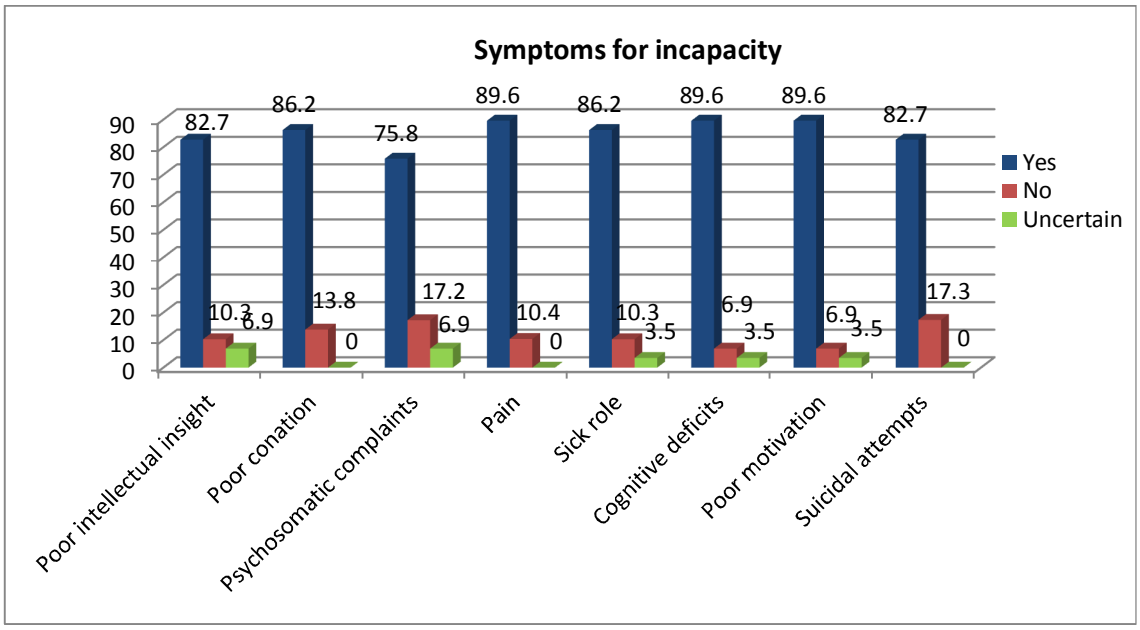

Figure XXVI: Symptoms to determine incapacity to return-to-work in phase two (n=29)

The participants confirmed on poor intellectual insight to condition (MDD), poor conation/ psychomotor activity, psychosomatic complaints, pain, sick role, cognitive deficits, poor motivation and suicidal ideas.

- **Phase three**

Supporting reflections by the participants relating to "temporary incapacity" were:

- ⇨ ñWith the first assessment you [therapist] cannot conclude permanent incapacity...you [therapist] must start with temporary incapacity ...later when you [therapist] do the reassessment you [therapist] can decide....ò
- ⇨ ñSometimes when therapists do work capacity evaluations they [therapist] conclude at that point without taking the progress of the condition or the potential for improvement into consideration.ò
- ⇨ ñWe [therapists] have to remember to leave the door open to allow the client [employee] to return to work at some stage and not put them [employees] at home permanently on a disability grant....ò
- ⇨ ñIf one [therapist] could manage external factors impacting on depression...the outcome could probably be more positive....ò

- ñThe implementation of reasonable accommodation that will enable that person [employee] to continue working....ò
- ñ...someone who is severely depressed in their initial stage but has not started to respond to treatment...one [therapist] cannot close the door and say that person [employee] cannot work...you [therapist] need to say after so long...month...reassess their [mention the duration of temporary incapacity] rehab potential or start looking at programs to return them [employeeôs] back to work.ò

Phase four

During phase four, the categories in Table 4.36 were found to be the determinants of temporary incapacity.

Table 4.36: Determinants of temporary incapacity (n=9)

Subtheme	Categories
Temporary incapacity	• Stage of recovery • Facilitate return to work • Manage external factors • Availability of reasonable accommodation • Has the patient received optimal treatment or not? • Implement programs of returning patient to work

Literature control: The occupational therapist should be able to determine the employeeôs duration of temporary incapacity and the time that the employee should be fit to return to their normal duties at work. Together with the client, the occupational therapist will need to identify possible strengths and barriers when coming to the decision about readiness to return-to-work[7]. If the client has an existing job to return to, there are additional workplace factors that may also affect the feasibility of their return-to-work as stated by Ross[7]:

- ñThe availability of modified duties;
- The employerôs existing return to work policies;
- The size of the company;
- The willingness of the employer for the person to return;
- The perceived value of the person to the company, both in financial terms and in terms of their skills, abilities and role within the company, and

- Their pre-injury or pre-illness attendance patterns and any outstanding capability or disciplinary issuesò (p.130).

Ross[7] agrees with the findings of the study that you need to take into account the personôs own strength, nature of their job and work tasks, the potential of accommodating them back into the workplace and the barriers to overcome, including the nature and stage of recovery of their health condition or disability. There are other factors that will make it difficult for the employee with MDD to cope at work. Many factors may contribute to employees dropping out from work such as the severity of symptoms, lack of insight and lack of family support[168].

vi) Subtheme 6: Declaring employee as permanently incapacitated

- **Phase one**

Refer to subsection showing the responses in phase one.

- **Phase two**

Figure XXIII illustrates that permanent incapacity is determined by the employees unresponsiveness to team treatment, which includes medication, individual and group therapy, persisting depressive symptoms for more than two years despite intervention, and high number of hospitalisation sessions without response.

Figure XXVII, illustrates other factors that confirm an employee who is suffering from MDD as permanently incapacitated.

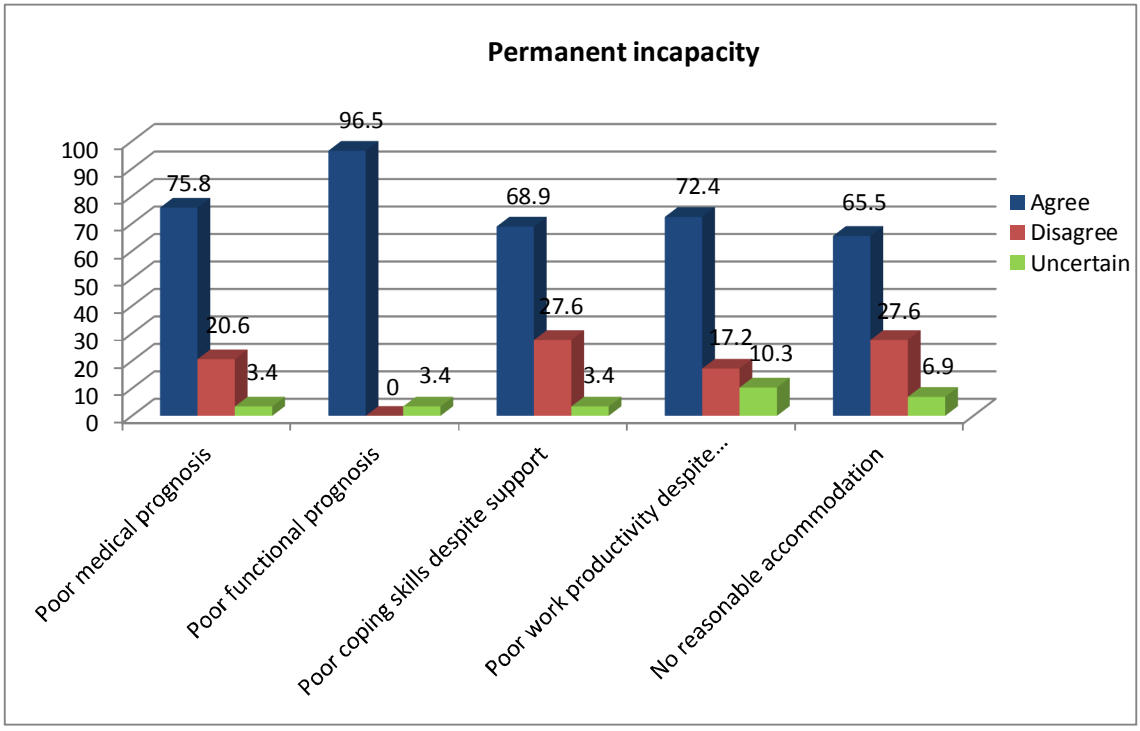

Figure XXVII: Determinants of permanent incapacity (n=29)

The illustrated aspects that have an impact in determining the employeeôs permanent incapacity to return to work are poor medical prognosis, poor functional prognosis, poor coping skills despite support, poor work productivity despite support and no reasonable accommodation.

- **Phase three**

Supporting reflections by the participants relating to "permanent incapacity" were:

- ⇨ ñFor permanent incapacity we [therapists] need to focus on the clients [employees] work functioning...investigate on their work ability....ò
- ⇨ ñIt is interesting to get the information from the work trial....ò
- ⇨ ñ...ascertain if they cannot cope with an alternative occupation....ò
- ⇨ ñ...long sick leave...it is difficult to return them [employees] back to work....ò

- **Phase four**

The categories in Table 4.37 were found to be the determinants of permanent incapacity

Table 4.37: Determinants of permanent incapacity (n=9)

Subtheme	Categories
Permanent incapacity	• Work ability/functioning • Long sick leave benefits • Unsuccessful work trials • Failure to cope with alternative occupation • Failure to cope with reasonable accommodation

Literature control: Permanent incapacity has a negative impact on the employees well being as they will never return to their workplace. Employees who have been on long sick leave for a number of years, loose their identity as a worker. As Ross[7] remarks that without a worker identity, a person is unlikely to aspire to achieving a worker role or they may clearly not be capable of returning to their former role. A longer period of sick leave makes the return-to-work more difficult and requires more resources[166].

The level of social functioning was found to be a strong and consistent predictor of vocational outcome[10]. If the employee still presents with social skills problems and low social functioning, the occupational therapist should not consider returning them to work.

vii) Subtheme 7: Determinants of the employee's level of motivation

The determinants of the employeeôs level of motivation were not discussed in phase one and phase two.

- **Phase three**

Supporting reflections by the participants relating to "the therapist's point of view of making return to work decisions" were:

- ⇨ ñYou [therapist] need to check the potential for secondary gains [for the employee]....ò
- ⇨ ñIf there is a need for secondary gains, you [therapist] need to assess the patientôs

personal issues or financial situation....ò

- ⇨ ñ...the patientôs [employee] ego strength to actually manage the job which might be impacted upon by factors such as social phobia...fear of returning to work...vigilant place that people are thinking of them, hypersensitivity of other peopleôs perception of them [employee with MDD]....ò
- ⇨ ñ...patients [employees] who have been off work for a long period of time...six months or more...their motivations to return to work are mostly affected....ò

- **Phase four**

During phase four, the following categories and subcategories in Table 4.38 were accepted by the participants.

Table 4.38: Determinants of the employee's level of motivation (n=9)

Categories	Subcategories
Intrinsic Motivation	• Drive
Extrinsic Motivation	• Transport • Family • Financial
Model of Creative Ability by Vona du Toit	Creative ability phases: • Therapist directed • Patient directed • Transitional phase Levels of Creative ability • Level of motivation • Level of action
Work environmental factors	• Disciplinary hearing • Retrenchment • Dismissal • Work stress • Degree of pathology
The intensity of work phobia	
Being off work for too long	

Literature control: The employeesô level of motivation will impact their ability to return-to-work. Crouch and Alers[10] are correct in observing that motivational problems do seriously impair a personôs will to even try to work. The Herzberg model of motivation describes humans as working for and through intrinsic and extrinsic motivators. Intrinsic motivators include personal achievement, recognition, responsibility and advancement of status, factors relating to the individual and the job itself[14]. Extrinsic or hygiene factors include pay

increase, competent supervision, improved working condition or job security, and factors which stem from the organisational context of work[14].

4.5 Conclusion

The findings of the research aim and objectives provided valuable information to the research study. Both showed that the perceptions of occupational therapists in determining work capacity with employees suffering from MDD should include the occupational therapistsô knowledge, experience and skill. This will help the occupational therapists to make proper decisions of returning the employee with MDD to an appropriate occupation.

The practice of occupational therapists while performing Work Capacity Evaluation with employees suffering from MDD covered the physical layout of the occupational therapy practice where the evaluation takes place, the assessment tools, which included the standardised measures and non-standardised assessments. It also explained that Work Capacity Evaluation is not limited to occupational therapy practice, but can extend to the employeeôs workplace and home environment for assistance with other observations.

4.6 Summary

This study had 68 participants, seven male and 61 female participants. Their demographic data included their gender, ages, areas of practice, participantsô years of experience, place of work, post- graduate qualifications, and province of work.

The age groups of the participants ranged from between 25 and 60 years in phase one, 25 and 55 years in phase two and 31 and 55 years in phase three. The majority of participants in phase one were in the age group 31-35 years, 31-40 years in phase two and 36-50 years in phase three.

The majority of participantsô area of practice in phases one, two and three was vocational rehabilitation followed by mental health. Their years of experience as occupational therapists ranged between six and 15 years in phase one and two and 11 and 30 years in phase three. The majority of participants who took part in phase one, two and three were employed in private practice, followed by those in universities.

The majority of participants in phase two had post-graduate qualifications and the researcher did not enquire about the specific nature of their qualifications. In phase one, the majority of participants had obtained their Post-Graduate Diploma in Vocational Rehabilitation and in phase three, they had Masters degrees.

The researcher formulated four objectives for this study and they were all achieved. The summary of the research aims and objectives are given in the Table below:

Research aim
The aim of this study was to describe the perceptions and practices of occupational therapists in determining work capacity of employees suffering from major depressive disorder.
The aim was partly discussed using the objectives of the study.
First research objective To determine the perceptions of occupational therapists when dealing with employees affected by MDD during WCE.
These were identified as the competency requirements of the occupational therapists which included the occupational therapistsô **Knowledge of:** • Pathology/conditions (Axis 1: MDD, Axis 2, Axis 3, Axis 4 and prognosis), • Guiding theories (MOHO, Model of Creative Ability by Vona du Toit, The Person Environment Occupation, Human Physiology, Clinical reasoning, vocational rehabilitation, Frames of references), • OT Knowledge (OT scope of practice, use and interpretation of tools, interventions), • WCE process and OT process • World of work (Legislation, Unions, Human Resource roles, Performance appraisal systems, industrial models, Reasonable accommodations and economic climate), • Knowledge of Ethical values (honesty, cost of evaluation and end of evaluation) and • Team members roles. **Experience of:** • Clinical work (especially in mental health, treating psychiatric diagnoses including MDD, general rehabilitation units and vocational rehabilitation) and • Life experiences (Wisdom and expert experience, understanding cultural differences, understanding manipulative behaviour/inappropriate illness behaviour). **Skills of:** • Interpersonal skills including negotiation skills and management skills. • Practice skills including: Building therapeutic relationships, Clinical reasoning, Work Capacity Evaluations (Obtaining medical information, Interview skills, problem-solving skills and observation skills), Professionalism skill, Administrative and Case Management skills and Research skills, and important factors to be taken into consideration by competent occupational therapists in Table 4.27.
Second research objective To identify current OT practices implemented during WCE of employees with MDD.

The current OT practices to perform WCE should include:

The physical layout:

- Structure of practice with waiting area, office, assessment room and group therapy room,
- Office equipment such as cupboards for records/files, computer with software and internet access and fax machine,
- Interview room with space for furniture,
- Assessment room with evaluation equipment, and
- Spacious treatment area for group therapy.

Assessment tools in the OT department:

- Standardised measures (VCWS 6, VCWS 201, T/PAL, Rivermead Behavioural Memory Test, WASP), MODAPTS for handwriting, reading, climbing stairs), Minnesota clerical tests and self report questionnaires (BDI, HADS, stress questionnaires, general health questionnaire and McGill pain questionnaire)
- Non-standardised assessments (Activities, practical groups)

Third research objective

To develop a possible process of WCE with employees suffering from MDD.

The process of WCE should emphasize on the following:

- The reason for referral,
- Information about the employee/client,
- Interviewing the client/employee,
- Collateral information (regarding the employee),
- Assessment (physical, psychological and functional),
- Collateral information(for confirmation) , and
- Making the decision of returning the employee to work

Fourth research objective

To formulate the general occupational performance that the occupational therapist should assess to determine the WCE of employees with MDD.

The Occupational therapist will use the above information to formulate the employeeôs occupational performance which should focus on:

- **Performance skills:**
  Motivation, affect, volition, insight, concentration, memory, emotional state, psychological endurance, physical endurance, perseverance, energy levels, frustration tolerance level, psychomotor activity, coping with failure and handling criticism.

- **Areas of occupation:**
  Activity profile, performing activities of daily living, functioning at home, coping with life responsibilities, social functioning, social skills, norm compliancy at work, work motivation, work endurance, work competency, work productivity, prognostic factors.

Formulating return-to-work decision:

- Clientôs/employeeôs biographical profile,
- Employeeôs point of view,
- Employerôs point of view,
- The therapistôs point of view,
- Declaring the employee for temporary incapacity,
- Declaring the employee for permanent incapacity, and
- Determinants of the employeeôs level of motivation.

CHAPTER 5

CONCLUSIONS, LIMITATIONS AND RECOMMENDATIONS

5.1 Introduction

Chapter 5 provides the final conclusion to the study, in which the five themes that formed the basis of the study are briefly summarised. Furthermore, recommendations are proposed based on the research findings. Finally, the researcher reflects on his experiences during the research and suggests future research around this area of enquiry.

The aim of the study was to describe the perceptions and practices of occupational therapists in determining work capacity of employees suffering from major depressive disorder.

In chapter 3 the researcher explained the methodology that was used to achieve the research aim and the objectives of the study. The research objectives were:

i. To determine the perceptions of occupational therapists when dealing with employees affected by MDD during WCE;
ii. To identify current OT practices implemented during WCE of employees with MDD;
iii. To develop a possible process of WCE with employees suffering from MDD; and
iv. To formulate the general occupational performances that the occupational therapist should assess in order to determine the WCE of employees with MDD.

These objectives were achieved with the assistance of participants who completed open-ended questions in phase one, close-ended questionnaire in phase two and those participants who took part in the discussion during the focus group interviews in phase three and member checking in phase four. The research findings were formulated and discussed in Chapter 4.

5.2 Conclusion to the study

5.2.1 Research themes which emerged

Information pertaining to the distribution of questionnaires in phase one and two and participation of participants in the focus group interview and member checking is illustrated under the discussion of the response rate in subsection 4.2. The demographic data revealed occupational therapists who had registered with the Health Professions Council of South Africa. There were more female than male participants in the ratio of 1:13 in favour of females. The median age of the participants ranged between 41 and 45 years. The length of experience in occupational therapy ranged between six and 40 years. Most of the participants were working in private practice and are staying in Gauteng Province.

Five themes emerged from the data analysis and were confirmed by an external auditor (co-coder), a senior lecturer specialising in mixed methodologies in the Department of Occupational Therapy, University of Pretoria. The supervisor undertook the same confirmation. The five themes were identified as the content of comprehensive assessment for Work Capacity Evaluation, the process of Work Capacity Evaluation, the competency requirements of the occupational therapist, occupational performance and formulating return-to-work decisions.

5.2.2 The content of comprehensive assessment for Work Capacity Evaluation

The comprehensive assessment provides an evaluation that is objective, comprehensive and effective. The content of comprehensive assessment for Work Capacity Evaluation was divided into the following subthemes: the physical layout of the OT practice, ways of obtaining medical information, the value of interviewing, tools in the OT Department, assessment of inappropriate illness behaviour, assessment at work and assessment at home.

Comprehensive assessment commences with the place of assessment for evaluation, which entails waiting area, office, interview room, assessment area and treatment area. The responses from the research participants did not differ from the recommendations in the

literature. Areas of confluence included the following: each room should have appropriate equipment such as cupboards for record keeping, a computer with software, internet access and fax machine for the office, appropriate furniture for the interview room, assessment tools in the assessment room and furniture in the treatment area.

The significance of background information prior to the comment of client evaluation was emphasised by the participants. It was unanimously said that the occupational therapist needs to obtain medical information on the client, i.e. background information, diagnoses, past and current treatment as well as particular precautions that need to be taken into consideration when dealing with specific clients.

The next recommended step was that the occupational therapist should then have initial contact with the employee during a comprehensive, intensive interview that should last for at least two hours. If there is a need for further information, the occupational therapist might need to interview family and/or the employer. The interview, most participants observed, will guide the therapist regarding choice of appropriate standardised measures and non-standardised assessments to use on the client. An observation was made that the assessment tools do not evaluate the employeeôs environment. The need to evaluate the employee at work and/or home to assess their interpersonal relationship and other environmental factors emerged from both the participants and the consulted literature.

It was further commented that for the comprehensive assessment to be objective, the occupational therapist needs to triangulate the findings, observations and collateral information for consistencies. The occupational therapist, it was also observed, needs to have the knowledge, experience and skill of assessing inappropriate illness behaviour including personality disorders due to the complex nature of the formulation of recommendations.

5.2.3 The process of Work Capacity Evaluation

In order to adequately evaluate an employee, the occupational therapist may need to undertake a logical, sequential process of Work Capacity Evaluation. The process entails clearly understanding the reason for referral, obtaining information about the employee, interviewing the employee, obtaining collateral information from the employer, family and treating specialists, physical assessment, psychosocial assessment, occupational performance

findings, collateral information to confirm the findings and formulate the return-to-work decision (refer to diagram 2).

5.2.4 The competency requirements of the occupational therapist regarding Work Capacity Evaluation

The competency requirements of the occupational therapist were based on their job responsibilities, abilities and quality improvement. The job responsibilities and abilities require an occupational therapistôs knowledge and skill. The knowledge of pathology, guiding theories, OT knowledge, process of the WCE, the world of work and ethical knowledge. Competencies also involve interpersonal skills and practice skills. The interpersonal skills include negotiation and management skills. Practice skills involve therapeutic relationship skills, clinical reasoning skills, Work Capacity Evaluation skills, administrative, case management and research skills.

Quality improvement is based on the occupational therapistôs experience, which includes clinical experience and life experience. The important factors for a competent occupational therapist in Table 4.27 should be taken into consideration for quality improvement.

5.2.5 Occupational performance

Occupational performance is subdivided into performance skills and areas of occupation. The performance skills that need to be assessed for an employee suffering from major depressive disorder entail motivation and drive, cognitive abilities, emotions, psychomotor activities, energy levels, endurance and self-management skills as reported by the study participants. The areas of occupation that need to be assessed include activities of daily living, social participation, work abilities and ability to cope with responsibilities and roles as well as general coping skills in life.

5.2.6 Formulating return- to- work decision

The main goal of Work Capacity Evaluation is to formulate return-to-work decision. Return-to-work decision is based on the employeeôs biographical profile, employerôs point of view,

employeeôs point of view, and the therapistôs point of view, which includes medical and psychosocial decisions. If the employee cannot return-to-work, the therapist needs to determine the extent of the incapacity as either temporary or permanent.

For temporary incapacity, the occupational therapist may need to assess the employeeôs support system, medical information, performance skills and areas of occupation as explained below:

- Employeeôs background information with regard to his/her level of education, previous work history and the type of job and support system from the family and work.
- Employeeôs medical history with regard to existence of psychotic episode, number of hospitalisations as a result of MDD, treatment compliancy, response to treatment, whether it is optimal treatment or not as well as side effects to medications.
- Employeesô symptoms such as psychosomatic complaints, pain and sick role.
- Performance skills such as mood and affect, insight, endurance, motivation, psychomotor activity, cognitive abilities, and self-management skills.
- Areas of occupation include energy to cope with basic activities of daily living, coping with home management tasks, work motivation, basic work habits, work speed, productivity level, work knowledge and skill, and work endurance.
- Work environmental factors such as employerôs willingness to reasonably accommodate, socio-political issues at work and blocking workplace.
- Employeesô intervention that includes management of external factors, rehabilitation potential and implementation of return-to-work programs. Occupational therapistôs intervention involves facilitation of an early return-to-work.

For permanent incapacity, the occupational therapist will need to evaluate the following factors: medical prognosis, functional prognosis, coping skills despite support, work productivity with support or reasonable accommodation, any available reasonable accommodation at work, coping abilities after a work trial, coping abilities with alternative occupation and duration absence from work. Other factors include the duration of sick absenteeism.

The employeeôs level of motivation has strong influence during the return-to-work process. There were important factors that need to be taken into consideration such as intrinsic and extrinsic motivation, employeesô level of creative ability, work environmental factors, the intensity of fear of returning to work (work phobia) and time off work.

These conclusion assisted the researcher to formulate recommendations that are related to the research study findings.

5.3. Recommendations

The recommendations were formulated from the research findings and are presented according to themes and subthemes from which they emerged. Ninety-one recommendations were formulated from the research, and are set out in Table 5.1 to Table 5.5.

5.3.1 The content of comprehensive assessment for Work Capacity Evaluation

The content of comprehensive assessment for Work Capacity Evaluation involves the

subthemes as illustrated in table 5.1 to Table 5.2.

Table 5.1: Recommendations related to the comprehensive assessment for WCE

Subthemes	Recommendations
The physical layout of the occupational therapy practice	1. The physical layout of the OT practice should have a waiting area, office with office equipmentôs such a cupboard for good record keeping, computer with software and internet access and fax machine, an interview room with a space for furniture, an assessment room with equipment for evaluation and spacious treatment area that accommodates group therapy. The assessment area (interview area and evaluation room) must be private without distractions (quite, warm and pleasant).
Obtaining medical information	Recommendations relating to obtaining medical information should include factors such as: 2. Background information (employees age, gender, pre-morbid functioning and socio-economic status).

Subthemes	Recommendations
	3. Diagnosis (cultural expression of depression, stage of illness, employeesô insight, stigma. 4. Treatment (compliancy to medication and correct dosages, stage of treatment, other alternative therapies, optimal treatment and coping skills). 5. Precautions or contraindications to be taken into consideration.
The value of interviewing	The value of interviewing is essential for collecting the employeeôs information in order to: 6. Understand their life story. 7. Trying to understand the employeeôs situation, to try and gather more information. 8. For assessment while observing their behaviour and identifying their strengths and potential problems and developing their occupational profile. 9. Reliability and clarification in order to confirm what was said in comparison to the findings. 10. Confidentiality to build an element of trust.
Tools in the occupational therapy department	Recommendations relating to ñstandardised measuresò include: 11. The recommended cognitive standardised measures such as the Rivermead Behavioural Memory Test, WASP especially for its cognitive assessment, the MODAPTS work samples for handwriting, reading, writing, comprehension and basic mathematics; COTNAB, Valpar Component Work Samples (T/PAL and VCWS 6); The Ross Test of Higher Cognitive Process and the Mini-Mental Status Examination. 12. It was suggested by this study that performing a comprehensive psychiatric evaluation as stated in DSM-IV-TR that includes thought process, mood and affect, psychomotor activity and cognition during and the use of self-report questionnaires will also be beneficial. 13. The recommended physical capacity measures are the MODAPTS work samples for climbing stairs and lifting, and Valpar Components Work Sample 201. 14. The recommended standardised measure to assess participation of employees doing activities of daily living is the AMPS. 15. It was further suggested by research participants that the occupational therapist will need to apply their decision-making and clinical judgement despite the usage of standardised measures and non- standardised assessments. It is advisable to administer the standardised measures for two days.

Subthemes	Recommendations
	Recommendations relating to ñself-report questionnairesò are: 16. HADS, BDI, Stress questionnaires, Quality of life scale, Interest checklist and General Health Questionnaire. 17. The suggested pain questionnaires, but not essential with employees suffering from MDD are the Randsfordôs Quantified Pain Drawing and the Mc Gill Pain Questionnaire. Recommendations relating to ñnon-standardised assessmentsò are: 18. Documents analysis. 19. Activity participation (wire-core tail, beads making, making tea and crafts). 20. Task centred groups. 21. Clinical observations. 22. Cross checking for triangulation, home visit or home assessment and worksite visits. Recommendations relating to ñcomplexities experienced during WCEò: 23. The occupational therapist needs to be experienced, knowledgeable and skilled in psychiatry/mental health and work capacity evaluations. 24. The occupational therapists need to develop their own standardised measures that assess psychosocial and vocational aspects. 25. The influence of work environment on performance should be taken into consideration during assessment and it will be helpful if such evaluations are performed in the workplace. 26. While performing work capacity evaluation, treat standardised measures and non-standardised assessments equally by embracing evidence-based practice and to augment with triangulation. 27. Be aware of the constraints and limitations of the practice setting.
Assessment of inappropriate illness behaviour	Recommendations relating to ñassessment of inappropriate illness behaviourò includes looking for: 28. Inconsistencies in the evaluation findings, suboptimal effort in performance or lack of cooperation during evaluation, poor level of motivation, presence of any personality disorder especially cluster B (borderline personality disorder, antisocial personality disorders) or cluster C (dependent and avoidant personality disorders), the presence of other diagnosis in Axis 1 (Anxiety disorders, Substance abuse disorder and psychotic disorders) and Axis 3 (HIV/AIDS, Neurological disorders) due to exaggeration of symptoms, poor support system and any possibilities of secondary gains due to lack of fund.

Subthemes	Recommendations
	29. The non-standardised assessments recommended are clinical observations, and gathering of collateral information. 30. The application of cross checking (triangulation) for assessment of inconsistencies in the findings and effort is also a necessity. 31. Assessment of inappropriate illness behaviour requires experience from the therapist due to the nature of its complexity.
Assessment at work	Recommendations relating to ñworksite visitsò are: 32. The need for an occupational therapist to know more about the employeeôs working environment, the job (job analysis), the wider work environment and the employerôs or colleaguesô view of the employee and employeesô interpersonal relationships at work.
Assessment at home	Recommendations relating to ñhome visitsò are: 33. Its value to assess the employee at home.

5.3.2 The process of Work Capacity Evaluation

Recommendations relating to the process of work capacity evaluation are illustrated in Table 5.2.

Table 5.2: Recommendations related to the process of WCE

Theme	Recommendation
The process of Work Capacity Evaluation	Recommendations relating to ñprocess of Work Capacity Evaluationò involves: 34. Understanding of the reason for the referral. 35. Obtaining information about the employee from various sources (employer and medical records). 36. Interviewing the employee to clearly understand their life story, obtain collateral information from the employer, family or referral resource or treating specialists. 37. Performing standardised measurements and non-standardised assessment (physical assessment, psychosocial assessment and functional assessment). 38. formulating return-to-work decision (can return to work or cannot return to work).

5.3.3 The competency requirements of occupational therapists to perform Work Capacity Evaluations

The recommendation relating to the competency requirements of the occupational therapist to perform Work Capacity Evaluations are illustrated in Table 5.3

Table 5.3: Recommendations related to the competency requirements of the occupational therapist

Subtheme	Recommendations
Occupational therapists knowledge	Recommendations relating to ñoccupational therapistôs knowledgeò include knowledge of: 39. Pathology (Axis 1, 2, 3, and 4). 40. Guiding theories (MOHO, MOCA, Person-Environment-Occupation Model, Frame of references, Vocational rehabilitation). 41. OT knowledge (OT scope of practice, use and interpretation of tools, intervention). 42. WCE process. 43. OT process. 44. World of work (Legislation, Human Resource roles, personal appraisal systems, industrial models, reasonable accommodations and economic climate). 45. Knowledge of ethical values (honesty, cost of evaluation, end of evaluation and maintaining a neutral stance at all times). 46. The literature suggested knowledge of occupational science, information technology and forensic issues, which were not discussed in the findings of the study.
Occupational therapists experience	Recommendations relating to ñoccupational therapistôs experienceò entail: 47. Clinical experience (previously worked in the field of mental health and vocational rehabilitation, experience of psychiatric pathologies including MDD). 48. Life experience (wisdom, expert experience, understanding cultural differences and identifying manipulative behaviour/inappropriate illness behaviour).
Occupational	Recommendations relating to ñoccupational therapists skillò entail:

Subtheme	Recommendations
therapists skill	49. The interpersonal skills include negotiation and management skills. 50. Practice skills include therapeutic relationship skills, clinical reasoning skills, work capacity evaluation skills (interview skills, observation skills, problem-solving skills), administrative and case management skills and research skills. 51. The literature highlighted interpersonal skills such as communication skills and leadership skills, which were not mentioned in the study.
Factors relating to competency requirements of the occupational therapist	Recommendations relating to ñoccupational therapistôs competencyò involve: 52. Verification of information received through collateral information and cross checking (interview, self-report questionnaires, medical information, standardised measures, non-standardised assessments and clinical observations) for consistency. 53. The question whether the symptoms are related to MDD or general medical condition. 54. Stage of illness-acute or chronic. 55. Interpersonal relationships at work. 56. Assessment that focuses on emotional status and vocational skills. 57. Consideration of two daysô assessment. 58. Knowledge of the employeeôs job. 59. Consideration of the employeeôs level of creative ability.

5.3.4 Occupational performance

Recommendations relating to the occupational performance are illustrated in Table 5.4.

Table 5.4: Recommendation related to occupation performance

Subtheme	Recommendations
Performance skills	Recommendations relating to ñperformance skillsò to assess employees with MDD are: 60. Emotional state (frustration tolerance level, affect, mood and self-esteem). 61. Motivation and drive/volition. 62. Psychomotor activity (agitation or retardation). 63. Cognition (attention and concentration, memory, insight, perseverance, problem solving, psychological endurance). 64. Energy levels and physical endurance.

	65. Hypochondriasis. 66. Self-management skills (coping skills, handling criticism).

Subtheme	Recommendations
Areas of occupation	67 Recommendations relating to the assessment of the areas of occupation include: 67. Twenty-four hour daily activity profile which includes ADLôs, work, and socialisation; 68. Activities of daily living (sleeping patterns, side effects of medication, functioning at home and home management); 69. Socialisation (social withdrawal, social skills, interpersonal skills); 70. Work area (prognostic factors, work motivation, work habits, norm compliancy at work, work skill, work speed, work endurance and work productivity); 71. Coping with responsibilities and roles as well as coping skills in life.

5.3.5 Formulating return- to- work decision

Recommendations regarding return-to-work decisions are illustrated in Table 5.5

Table 5.5: Recommendations related to formulating RTW decisions

Subtheme	Recommendations
The employeeôs biographical profile on formulating return to work decision	72. Recommendations relating to ñbiographical profileò on formulating return to work decisions are the employees age and gender.

Subtheme	Recommendations
The employerôs perspective on formulating return-to-work decisions	Recommendations relating to ñemployers point of viewò to return-to-work decision are related to the employeeôs: 73. Past work history, poor work records, ñblockingò workplace, issues of constructive dismissal, employerôs ignorance and unwillingness to implement reasonable accommodations.
Employeeôs perspective on formulating return-to-work decisions	Recommendations relating to ñemployeesô point of viewò on return-to-work decision are based on the following barriers: 74. Fear of returning to work, secondary gains, stigma, lack of work skill and poor work motivation.
The therapistôs perspective on formulating return-to-work decisions	Recommendations relating to ñtherapistôs point of viewò on formulating return-to-work decision are based on medical and psychosocial decisions: 75. The medical decision include the employees degree of pathology (severity of MDD), impact of Axis 2, 3 and 4, impact of occupational performances, possible rehabilitation potential, work endurance, psychiatrists support and time off work. 76. The psychosocial decision includes the employeesô social expectation at work, impact of interpersonal relationship at work, support system from work, home and team, previous attempts to return the employee to work, any available programs of preparing the employee for return to work, potential for re-skilling or any transferable skills, supportive work trials for three months and the investigation of the job and the environment.
Declaring employee as temporary incapacitated	Recommendations relating to ñtemporary incapacityò are based on the following information that needs to be taken into consideration: 77. Employeeôs background information with regard to his/her level of education, previous work history and the type of job and support system available from the family and work. 78. Employees medical history with regard to existence of psychotic episode, number of hospitalisations as a result of MDD, treatment compliancy, response to treatment (whether treatment is optimal or not and side effects of medications). 79. Employeesô symptoms such as psychosomatic complaints, pains and sick role. 80. Performance skills such as mood and affect (severe depression, emotional

Subtheme	Recommendations
	instability, irritability, poor frustration tolerance), insight (poor intellectual insight), endurance (poor psychological endurance, poor physical endurance and poor physiological endurance), motivation (poor motivation and drive), psychomotor activity (psychomotor retardation, agitation, hypo-activity), cognition (poor concentration, poor perseverance, poor memory, poor executive functioning, suicidal ideas) and self-management skills (poor coping skills, poor frustration tolerance, inability to handle criticism). 81. Areas of occupation such as difficulty and low energy to cope with basic activities of daily living, difficulty to cope with home management tasks, poor work motivation, poor basic work habits (absenteeism, poor interpersonal relationship, poor social skills, poor accuracy, difficulty to correct errors, inability to sustain effort, poor task completion), poor work speed, reduced productivity level, poor work knowledge and skill and poor work endurance. 82. Work environmental factors such as employerôs unwillingness to reasonably accommodate, employeesô socio-political issues at work, blocking workplace. 83. Employeesô intervention that includes management of external factors, rehabilitation potential and implementation of return-to-work programs. Therapistôs intervention involves facilitation of early return-to-work.
Declaring employee as permanently incapacitated	Recommendations relating to ñpermanent incapacityò are based on: 84. Poor medical prognosis, poor functional prognosis, poor coping skills despite support, poor work productivity despite support or reasonable accommodation, no reasonable accommodation at work, unable to cope during work trial, unable to cope with simple alternative occupation and long sick benefits without recovery. 85. Other factors include unresponsiveness to team treatment that includes medication, individual and group therapy, persisting depressive symptoms for more than two years despite medication and high number of hospitalisations without response.

Subtheme	Recommendations
Employees level of motivation	Recommendations relating to ñthe employees level of motivationò are based on the following factors that need to be taken into consideration: 86. Internal motivation/internal drive to work. 87. Extrinsic motivation (transport to work, family circumstances, financial circumstances). 88. Applying the Model of Creative Ability (levels of creative ability and their phases). 89. Work environmental factors (disciplinary hearing cases against the employee, possibilities of retrenchment, possibilities of dismissal, work stress due to environmental factors, degree of pathology which affect work performance). 90. The intensity of fear of returning to work (work phobia). 91. Being off work for a longer period of time.

5.4 Non consensus items

The research participants did not achieve consensus in all the items in phase two of the close-ended questionnaire and those items were not mentioned in phase three or phase four of data collection. These include:

- Standardised measures such as: Jamar hand dynamometer, BTE, VCWS 9, JOULE®FCE, BaFPE, Thurstone test and COPM. Most of these standardised measures are extensively used internationally, and the possible reason for less-consensus with the South African occupational therapists could be the occupational therapistsô lack of exposure to the tests, the cost of purchasing the tests or their non-availability in South African market. The COPM and BaFPE are used a lot internationally in mental health care practices but they did not reach consensus in this study. The BTE, VCWS 9, JOULES®FCE and Jamar hand dynamometer are used mostly for physical conditions which might be the reason for their non-consensus, even though some occupational therapists prefer their qualitative results during assessment with employees suffering from MDD. The self-report questionnaires which did not reach consensus were the Zung Depression Scale and pain questionnaires. It was surprising that there was no consensus on the use of pain

questionnaires given that increasingly, more employees with MDD report physical symptoms of pain.

- The measure to determine incapacity, which did not reach consensus, was the employeeôs frequent relapses of MDD episodes.

5.5 Evaluation of the study

5.5.1 Limitations to the study

This research study was limited to the view, perceptions and practices of occupational therapists registered with the Health Professions Council of South Africa. The views of other health professionals in other disciplines were not explored.

There were complaints from the participants regarding the length of the close-ended questionnaire in phase two that it was too long. If the researcher had compiled the close-ended questionnaire after phase three and phase four, it was going to be shorter as most items would have been agreed upon. It took a longer time for the researcher to receive responses of close-ended questionnaires in phase two due to the above-mentioned reason.

The focus group interviews and member checking only catered for the views, perceptions and practices of occupational therapists who practice in the Gauteng Province, either in Johannesburg or Pretoria. The researcher had only two focus group interviews with 11 participants, only from Gauteng Province, which limited the data received to practitioners and practices in this area. The limited sample size for the focus group was a concern to the researcher as more participants were expected. During member checking in phase four, the researcher wanted to validate the findings of phase three, and additional new information, which was relevant to the study, was brought forward, which questions saturation of data in phase three. The scribes in phase three gave minimal contribution to the discussion to clarify some of the terms and issues as they are experienced in the field of mental health.

With regard to the title of the study, the researcher should have used the term Functional Capacity Evaluation instead of Work Capacity Evaluation. Much as these terms are used

interchangeably, Functional Capacity Evaluation has gained more currency and is used more often.

Even though the study is limited to the diagnosis of major depressive disorder, the researcher assumes that the research findings and recommendations can be applied to other diagnoses in mental health that are found in the DSM-IV-TR where Work Capacity Evaluation is needed.

The research process of this study was lengthy and resulted in a huge amount of data that was generated. Some of the data important as it was, had to be discarded as they were not needed for the research objectives.

5.5.2 Strengths of the study

The following are strengths of this study:

- The researcher managed to involve the experts in the field of mental health and vocational rehabilitation during the focus group interview in phase three and member checking in phase four.
- The researcher was involved in the field of vocational rehabilitation and mental health and ensured that the findings of this research study were trustworthy. The researcher bracketed himself and used the information presented by the participants, used independent co-coder and lecturers to scrutinise the data.
- The researched succeeded in achieving the aim and objectives of the study. When the researcher reviewed objective 3 and 4, it was noted that it was above the aim of the study.
- The researcher triangulated the data throughout the study.
- The researcher was involved throughout the process of the research study including the writing up of the entire thesis.
- Literature supported the findings of this study as discussed in Chapter 4. It was interesting to note that the practices of South African occupational therapists are in par with international standards.

5.6 Recommendations for future research

Future research topics that emerged from this research study are:

- Determining the return-to-work decisions with employees suffering from major depressive disorder.
- Performing a comprehensive assessment of inappropriate illness behaviour [malingering] with clients suffering from major depressive disorder.
- To determine how effective current South African legislation is in returning mental health care clients to work.
- The practicality of the process of Work Capacity Evaluation that was formulated in this research study.
- Professional competencies required of the occupational therapists who deliver Work Capacity Evaluations or Functional Capacity Evaluations in mental health.
- The influence of personality disorders while facilitating the return-to-work decisions.
- The effects of physical capacity evaluation on return-to-work decisions with clients suffering from major depressive disorder.
- Development of tools for occupational therapy practitioners who work with clients suffering from MDD.
- Development of an occupational therapy standardised measure for assessment of psychosocial FCE.
- To conduct research study into the need for further Post Graduate qualifications into the field of vocational rehabilitation and mental health.

5.7 Researcher's personal reflection

The researcher is an occupational therapist who works in the field of mental health and vocational rehabilitation. The researcher learned that the main purpose of performing Work Capacity Evaluation with employees suffering from major depressive disorder is to formulate a return-to-work decision. The return-to-work decision is challenging as there are factors and obstacles that need to be taken into consideration prior to achieving this goal.

This study has clarified that Work Capacity Evaluation is not about the employee being assessed through standardised measures and leaving the practice. It is a lengthy process that

requires an occupational therapistsô competency in the use of standardised measures and non-standardised assessments. It is the experience of the occupational therapist, the ability to triangulate the information throughout the assessment from the beginning, in order to make an objective and justifiable decision about the future of an employee who is suffering from major depressive disorder.

It was also interesting to note that even though the occupational therapy measurements do not assess the employeeôs environment in the occupational therapy practice, it is advisable for the occupational therapist to perform their Work Capacity Evaluations at the employeeôs workplace or home in order to obtain clearer collateral information and to observe the employeeôs environment.

It was also emphasized that Work Capacity Evaluation requires a lot of wisdom, maturity and expert experience from the occupational therapist so that it is of a high quality and integrity. This information helped the researcher to realise the significance of the occupational therapist who performs Work Capacity Evaluations and that he/she still is, and will remain an advocate of the patient [employee], and that the assessment should be performed with honesty and integrity preferably for two days in order to achieve a comprehensive assessment.

What surprised the researcher was the fact that experienced expert occupational therapists find this area of Work Capacity Evaluation with employees suffering from major depressive disorder challenging as they have to continuously think and apply their clinical reasoning, professional judgement and the guiding occupational therapy theories throughout the evaluation process. This area of mental health and vocational rehabilitation while working with employees suffering from major depressive disorder requires lot of analytical and abstract thinking for the outcome to be efficient and justifiable. It is a science and an art combined.

It was further noted that it is not Work Capacity Evaluation, but the occupational therapist needs to know the occupational performances that need to be assessed while evaluating employees suffering from MDD. It is not about the assessment tools (standardised measurements and non-standardised assessments); it is about the knowledge, experience and skill (occupational therapists competency) in performing Work Capacity Evaluations with employees suffering from major depressive disorder.

This information clarified and confirmed that occupational therapists have a major role to play in performing Work Capacity Evaluations with employees suffering from major depressive disorder. The reason for disagreement with regard to the occupational therapistsô findings and recommendations of the employees capacity is based on their lack of knowledge, experience and skill [incompetency] in performing evaluations.

5.8 Conclusion

In this chapter, the final conclusion of this study was summarised based on the aim and objectives of the research study.

The recommendations were formulated based on the research findings. The limitations of the study were also indicated. In addition, the recommendations regarding future research and the researcherôs personal reflection were highlighted.

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Appendix 1: Descriptive questions

Participant's information leaflet and informed consent for anonymous questionnaire

Researcherôs name: Mr. Enos Ramano
Department of Occupational Therapy
University of Pretoria
e-mail: ramano@accessweb.co.za
Tel: 0825742720

Dear Participant.é é é é é é é é é é é Dateé é é é . /é é é /é é é .

TITLE OF STUDY

Perceptions and practices of occupational therapists in determining work capacity of employees suffering from major depressive disorder.

I, Enos M. Ramano, am a MOccTher student in the Department of Occupational Therapy, University of Pretoria. You are invited to volunteer to participate in our research project on perceptions and practices of occupational therapists in determining work capacity of employees suffering from major depressive disorder.

This letter gives information to help you decide if you want to take part in this study. Before you agree you should fully understand what is involved. If you do not understand the information or have any other questions, do not hesitate to ask us. You should not agree to take part unless you are completely happy about what we expect of you.

The purpose of the study is to describe the current practices of occupational therapists with regard to determining the work capacity of employees suffering from major depressive disorder and the reason thereof and to explore ways of standardising strategies for evaluating work capacity of these clients.

We would like you to complete this questionnaire. This may take about fifteen minutes of your time. Please e-mail back the questionnaire to the above indicated e-mail address or post it back in the franchised envelope. It will be kept safe to ensure confidentiality. Please do not write your name on the questionnaire.

The Research Committee of the University of Pretoria, Faculty of Health Sciences granted written approval for this study.

Your participation in this study is voluntary. You can refuse to participate or stop at any time without giving any reason. As you do not write your name on the questionnaire, you give us the information anonymously. Once you have given the questionnaire back to us, you cannot recall your consent, as we will not be able to trace it. Therefore, you will also not be identified as a participant in any publication that comes from this study.

We sincerely appreciate your help.

Yours truly

Enos Ramano

Demographic information

- Participant no: (to be completed by the researcher)
- Gender:
- Age:
- Place of work:
- Position held:
- Province of work:
- Institution of undergraduate qualification:
- Year obtained:
- Year obtained post graduate diploma in vocational rehabilitation:
- Speciality:
- Other post graduate qualification(s), institution(s) and year(s) obtained:
- Years of experience:

Questions:

1. What is your general understanding of work capacity as it relates to major depressive disorder (MDD)?

2. When will you consider a client with MDD to be incapable of working?

3. What formal and informal methods of evaluation do you use to evaluate the work capacity of clients with MDD?

4. What are the reasons for using these methods or tools for clients with MDD?

5. What would you consider to be the main problems with the use of occupational therapy tools for determining work capacity?

6. Which important factors do you take into consideration when determining work capacity/ incapacity of clients suffering from MDD?

7. Which important factors/observations from the assessment results do you take into consideration to conclude on a clientôs work incapacity for those who are diagnosed with MDD?

8. Please elaborate on the areas where you feel occupational therapists have difficulties in the determination of work capacity.

9. What would you advise other occupational therapists to be aware of or take into consideration when assessing a client with MDD?

10. Please describe the process or steps that you think a competent occupational therapist should follow when performing work capacity evaluation of MDD clients?

11. What impact do you think personality disorders have on work capacity assessment? (You may answer according to different personality disorders)

12. How do you exclude malingering while assessing clients with MDD?

13. Which other conditions do you think have a negative impact with regard to the work capacity assessment of clients with MDD and how?

14. Have you ever been involved in a dispute involving MDD cases? Yes/No

    Any comments you would like to share about it:

15. Any other comments or suggestions that could help other occupational therapists in their evaluation of work capacity/incapacity of clients with MDD:

Appendix 2: Close-ended questionnaire

Participant's information leaflet and informed consent for anonymous questionnaire

Researcher: Mr. Enos Ramano
Department of Occupational Therapy, University of Pretoria
E-mail: ramano@accessweb.co.za
Tel: 0825742720

Dear Participant Date: 03/03/2008

TITLE OF STUDY

Perceptions and practices of occupational therapists in determining work capacity of employees suffering from major depressive disorder [MDD].

I, Enos M. Ramano, am a MOccTher student in the Department of Occupational Therapy, University of Pretoria. You are invited to volunteer to participate in our research project on perceptions and practices of occupational therapists in determining work capacity of employees suffering from major depressive disorder.

This letter gives information to help you decide if you want to take part in this study. Before you agree you should fully understand what is involved. If you do not understand the information or have any other questions, do not hesitate to ask us. You should not agree to take part unless you are completely happy about what we expect of you.

The purpose of the study is to describe the current practices of occupational therapists in determining the work capacity of employees suffering from major depressive disorder and the reasons thereof and we wish to explore ways of standardising strategies for evaluating work capacity with these clients.

We would like you to complete this questionnaire which is compiled from the data of a previous descriptive survey. It may take about twenty minutes of your time to complete this questionnaire. Please e-mail back the questionnaire to the above mentioned e-mail address or post it back with the franchised envelope. It will be kept safely to ensure confidentiality. Please do not write your name on the questionnaire.

The Research Committee of the University of Pretoria, Faculty of Health Sciences granted written approval for this study.

Your participation in this study is voluntary. You may refuse to participate or stop at any time without giving any reason. As you do not write your name on the questionnaire, you give us the information anonymously. Once you have given the questionnaire back to us, you cannot recall your consent, as we will not be able to trace it. Therefore, you will also not be identified as a participant in any publication that comes from this study.

We sincerely appreciate your help.

Yours truly

Enos Ramano

Demographic information

0.1 Participant no: (to be completed by the researcher)

0.2. Gender:

Male		Female	

0.3 Age: _____ years

0.4 Place of work:

Private Practice	☐	Private Clinic	☐	Insurance/Consultancy	☐
School	☐	University	☐	Company	☐
Provincial Hospital	☐	Rehabilitation Centre	☐	Other (specify)	☐

0.5 Province of work:

Gauteng	☐	Western Cape	☐
Mpumalanga	☐	KwaZulu-Natal	☐
Limpopo	☐	Other (specify)	☐

0.6 Any postgraduate qualification?

Yes ☐ No ☐

0.7 If Yes, year obtained: _____

0.8 Field of expertise: _____

0.9 Years of experience: _____

Themes

You are only expected to tick Yes or No, throughout this questionnaire. If you do not know or you are not sure you may tick uncertain.

1. The following methods of evaluation are suggested by occupational therapists in determining work capacity with clients suffering from major depressive disorder.

	Yes	No	Uncertain
1.1. Interview			
1.2. Collateral information (family/employer/health Team)			
1.3. Constructive/Creative activities (Individual/ group)			
1.4. Clinical observation			
1.5. Physical testing			
1.5.1. Intermittent Jamar Dynamometer			
1.5.2. VCWS 9: Whole body range of motion			

	Yes	No	Uncertain
1.5.3. VCWS 201: Physical capacity and mobility screening evaluation			
1.5.4. JOULE®FCE			
1.6. Mini-Mental Status examination			
1.7. Comprehensive psychiatric assessment			
1.8. Standardised measurements/formal testing			
1.8.1 MODAPTS			
1.8.2. WASP			
1.8.3. COTNAB			
1.8.4. T/PAL			
1.8.5. VCWS6: Independent problem solving			
1.8.6. Minnesota clerical test			
1.8.7. Rivermead Behaviour Memory Test			
1.8.8. Cognitive assessment of Minnesota			
1.8.9. LOTCA			
1.8.10. Thurstone test			
1.8.11. The Ross Test of Higher Cognitive Process			
1.8.12. Detroit Test of Learning Aptitudes			
1.8.13. TVPS [upper level]			
1.8.14. VMI			
1.8.15. Canadian Performance Model			
1.8.16. Assessment of Motor and Process Skills (AMPS)			
1.8.17. BCAB			
1.8.18. BTE			
1.8.19. BaFPE			
1.9. Self-report questionnaires			
1.9.1.Pain questionnaires (Specify:_____)			
1.9.2. Beck depression inventory			
1.9.3. Hospital Anxiety and Depression Scale (HADS)			
1.9.4. Stress questionnaires (Specify:_____)			
1.9.5. Zung Self-Rating Depression Scale			
1.9.6. Quality of Life Scale			
1.9.7. General Health Questionnaire			
1.9.8. Hamilton Rating Scale for Depression			
1.9.9. Glazer			
1.9.10. DASS			
1.10. Work Visit			
1.11. Job Analysis			

	Yes	No	Uncertain
1.12. Home Visit			
1.13. Document analysis (medical reports, copy of job description, and other available documents)			
1.14. Cross checking (triangulation for consistency)			

Any other comment _____

_____

_____

_____

_____

_____

2. For the clients suffering from major depressive disorder to be declared incapacitated to work, they need to meet the following criteria. Answer with agree or do not agree. Note that there is another column where you decide if that criterion will determine temporary or permanent incapacity or you may tick both if you think that it determines both.

   Clients suffering from major depressive disorder are incapable of working if:

	Agree	Do not agree	Uncertain	Temporary	Permanent
2.1. They have a long history of depression for more than two years with:					
2.1.1. recurrent or frequent relapses despite treatment compliancy					
2.1.2. unresponsiveness to optimal multi-disciplinary intervention (medication, psychotherapy and group therapy)					
2.1.3. depressive symptoms persist for more than two years despite medication or other interventions.					
2.1.4. psychotic features					
2.1.5. a high risk of Suicide (danger to self or others)					
2.1.6. Side effects to medication					
2.1.7. high number of hospitalisation and long length of stay [±5 admissions & ±21 days per stay in a two year cycle].					

	Agree	Do not agree	Uncertain	Temporary	Permanent
2.1.8. poor medical prognosis					
2.1.9. poor functional prognosis					
2.2. They are in the acute phase of depression.					
2.3. The following occupational performance components are affected:					
2.3.1. Cognitive deficits such as forgetfulness, poor concentration, poor insight, poor problem solving skills, difficulty following instructions					
2.3.2. Conation					
2.3.2.1. Poor motivation					
2.3.2.2. Poor psychological endurance					
2.3.2.3. Poor perseverance					
2.3.2.4. Psychomotor agitation					
2.3.2.5. Psychomotor retardation					
2.3.3. Emotions					
2.3.3.1. Severely depressed					
2.3.3.2. Affective instability					
2.3.3.3. Irritability					
2.4. The following Self Management Skills are affected:					
2.4.1. Poor coping skills					
2.4.2. Poor stress tolerance in a workplace					
2.4.3. Poor coping skills despite training or support					
2.5. The following Occupational performance Areas are affected:					
2.5.1. Struggling to carry daily tasks at home					
2.5.2. Poor interpersonal ability (Specify:_____)					
2.5.3. Poor social skill (Specify: _____)					
2.5.4. Poor work habits (Specify: _____)					
2.5.5. Poor work productivity [past and present]					
2.5.6. Poor work speed					
2.5.7. Poor work motivation					
2.5.8. Poor work endurance					
2.5.9. Poor work knowledge					

	Agree	Do not agree	Uncertain	Temporary	Permanent
2.5.10. Poor work skill					
2.6. Their working environment influences them as follows:					
2.6.1. it aggravates their depressive condition					
2.6.2. they have poor work productivity despite reasonable accommodations					
2.6.3. the co-workers cannot cope with Clientôs behaviour and depressive state					
2.6.4. they experience socio-political issues in the workplace					
2.6.5. there is no possibility of reasonable accommodations or alternative occupation					
2.6.6. there is negative attitude of the employer towards the client or mental illness					

Any other comment _____

_____

_____

_____

_____

_____

3. Limitations exist while using Occupational Therapy tools to determine work capacity with clients suffering from major depressive disorder.

	Agree	Do not Agree	Uncertain
3.1 Work environment			
3.1.1. Our tests cannot exactly simulate the real job environment and the real job task			
3.1.2. Our tests cannot assess the true work environment factors that might be the important stressor to the client			
3.1.3. Interpersonal relationship at work cannot be Assessed			
3.2. Limited Occupational Therapy standardised tools for psychiatric clients			
3.3. Standardised tools are not applicable to the South African community/population			

	Agree	Do not Agree	Uncertain
3.4. We have few South African standardised tests, which makes acquiring the test very expensive			
3.5. The standardised tools are not a true reflection of a Clientôs real work area, which makes it difficult for the therapist to give a clear view of a personôs ability to perform their own job			
3.6. The results are not always reliable since they are influenced by a clientôs mood on that day			
3.7. The tests are time consuming			
3.8. Our depression, pain and stress questionnaires are often developed by psychologists and our interpretation may differ from the initial purpose that they were developed for			
3.9. To a certain extent the tests are unrealistic as they cannot match the exact ability/skill to a direct job specification			
3.10. We have few criterion reference based tests.			
3.11. The tests are quite contrived and may not be true to the complexity of jobs that we need to assess people for, especially higher level managerial assessments			
3.12. Assessment usually takes place in a supported environment, not necessarily the real environment or world, which does influence the results			
3.13. Clients with psychiatric diagnosis often present with intangible and often immeasurable problems. Even if you have obtained functional results, it does not mean a client is able to function, it depends on the therapistôs interpretation to substantiate non-functionality			
3.14. It is noted that during the work visit, the presence of the occupational therapist already influences the wok atmosphere			
3.15. We may need to develop a detailed performance appraisal system, which will look at the clientôs performance components			
3.16. We have limited norm referenced tests for clients suffering from major depressive disorder			
3.17. The clients suffering from MDD are fragile and they relapse now and then due to poor coping skills (trained/not trained). We are not able to foresee exactly to what extent these challenges will affect their coping skills.			
3.18. Difficulty to quantify the extent to which MDD clients are limited in their functioning			
3.19. We are not able to measure cognitive skills needed to perform certain types of work for example we use the same tests to assess a patient employed as a cleaner and a chemical engineer			

Any other comment_____

4. The following are the difficulties that are experienced by Occupational Therapists while performing work capacity with clients suffering from MDD.

	Yes	No	Uncertain
4.1. We have few standardised assessment tools available to look at psychiatric type of symptoms rather than using tests for other diagnostic group and or age group			
4.2. Most of our tests focus a lot on cognitive aspects and not on psychosocial and or vocational aspects			
4.3. We experience difficulties in assessing the influence of the work environment on the client			
4.4. We have difficulties in assesings the existence of victimisation by the supervising staff/colleagues			
4.5. We have difficulties to predict specific ability to cope at Work			
4.6. It is difficult for the therapist to extrapolate from the clinical assessment to the real life situation especially with regard to social skills			
4.7. Therapists underestimate their own clinical knowledge and clinical observation skills, and rely too much on formal tests			
4.8. Therapists experience difficulties in handling patientsô manipulation and therapists are being sympathetic			
4.9. Many OTs who perform FCEs are not experienced in the field of psychiatry. Their level of knowledge in work capacity evaluation is a major concern.			
4.10. We have difficulty to assess clientôs work load or work Pressure			
4.11. There is not enough awareness of case management opportunities or other mental health rehabilitation providers			
4.12. I feel that assessment of malingering needs more scientific guidelines for the occupational therapists			
4.13. It is difficult to determine a conclusion when the pre-morbid level of functioning is high and the impact of functioning is subtle			

Any other comment _____

5. The following aspects may have a negative prognostic effect while doing work capacity with clients suffering from MDD.

	Yes	No	Uncertain
5.1. Conditions/Disorders			
5.1.1. Anxiety disorder/co-morbid anxiety disorder			
5.1.2. Post traumatic stress disorder (PTSD)			
5.1.3. HIV/AIDS			
5.1.4. Substance abuse [drug/alcohol abuse]			
5.1.5. Chronic fatigue			
5.1.6. Chronic pain conditions [lower back pain, arthritis]			
5.1.7. Neurological disorders that impact on cognitive abilities especially self-perception and executive functioning e.g. stroke			
5.1.8. Organic brain syndromes			
5.1.9. Paranoid schizophrenia			
5.1.10. Aspergerôs			
5.1.11. Sick role/illness behaviour			
5.2. Symptoms			
5.2.1. Pain			
5.2.2. Suicidal attempts (previously/present/future plan)			
5.2.3. Poor motivation			
5.2.4. Severe cognitive deficits			
5.2.5. Poor intellectual insight			
5.2.6. poor conation			
5.2.7. Psychosomatic complaints			
5.2.8. Visual perceptual skills problems			
5.3. Self management skills			
5.3.1. poor coping skills			
5.3.2. Slow responses			
5.3.4. Poor self control			
5.4. Background information			
5.4.1. Age			
5.4.2. Gender			
5.4.3. Race			
5.4.4. Low level of education			
5.5. Support system			
5.5.1. Lack of social support structure			
5.5.2. Poor insight from clientôs family regarding his/her Illness			
5.5.3. Poor insight from clientôs employers regarding his/her Illness			
5.5.4. Negative family relationship/interference			
5.5.5. Employerôs attitude towards the client with mental Illness			
5.5.6. Employerôs unwillingness to consider reasonable accommodations			

	Yes	No	Uncertain
5.6. Socio-economic factors			
5.6.1. Lack of funds which lead to non-compliancy to treatment/therapy			
5.6.2. Poor access to resources such as transport, job advertisement and corporate clothing			
5.7. Clinical reasoning			
5.7.1. It is a matter of clinical reasoning which will not be possible to delineate every scenario			
5.8. Precautions			
5.8.1. Patients with acute physical/mental symptoms should not be assessed until recovered			
5.8.2. Involvement in a legal process makes the client paranoid, uncooperative and cautious on the information to divulge or not			

Any other comment _____

_____

_____

_____

_____

_____

6. To perform a professional work capacity evaluation with clients suffering from MDD the following factors should be taken into consideration by a competent occupational therapist.

	Yes	No	Uncertain
6.1. Make sure that you always verify information by getting/obtaining collateral information from treating specialists, family members or employers			
6.2. Cross checking is very important to ensure that there is consistency during the interview replies, self-report questionnaires, medical information, test results and the behaviour observed			
6.3. It is important to note whether the clientôs response or symptoms are due to the depression or the medication side affects			
6.4. The stage of an illness either acute or chronic should be seriously taken into consideration during an FCE			
6.5. FCE should always be performed on clients who are stabilised on treatment for minimum of 6 months or more			
6.6. Always think critically about the clientôs diagnosis and functional impairment. Be aware of the possibilities of misdiagnosis			
6.7. The phase in which the client is, i.e.: pre or post admission or whether his/her condition is in remission			
6.8. Always check for signs of heightened or depressed mood			

	Yes	No	Uncertain
and the clientôs stress tolerance			
6.9. It is very important for the client to be able to handle symptoms such as frustration, lack of motivation, short temper, poor social interaction in such a way that the work capacity can be seen as separate to these problems			
6.10. Look at interpersonal relationships at work, possibilities of promotions, demotions, disciplinary actions at work and other labour related issues			
6.11. Most MDD employees are not motivated to work, so they may pretend to be very sick or incompetent in order to get their secondary gains. It is important to focus your assessment on their emotional status and vocational skills			
6.12. One should assess a client on more than one occasion to control the effect of good and bad days			
6.13. Do not be biased about the assessment results			
6.14. Be as specific and practical as possible while writing the final report (make report simple and professional)			
6.15. Be consistent with the evaluation process and ensure that you cover all the performance areas			
6.16. The therapist should ensure enough knowledge about the clientôs work [job description/job analysis] before reaching a conclusion			
6.17. Always discuss the importance of the assessment with the client			
6.18. Intermitted Jamar Dynamometer rapid exchange testing coupled with MODAPTS handwriting will assist to exclude malingering			
6.19. The therapist should always check for consistency in effort and task execution			
6.20. Always look at the clientôs level of creative ability during activity participation.			

Any other comment _____

_____

_____

_____

_____

_____

Thank you for your participation

Please return this questionnaire:

Via e-mail to: ramano@accessweb.co.za or fax (011) 421-7300 or

Hard copy: P.O.Box 751738
Gardenview
2047

Appendix 3: Focus group interview guide.

Participant's information leaflet and informed consent for the focus group interview

Researchers name: Mr. Enos Ramano
Department of occupational therapy
University of Pretoria
e-mail: ramano@accessweb.co.za
Tel: 0825742720

TITLE OF STUDY

Perceptions and practices of Occupational Therapists in determining work capacity with employees suffering from major depressive disorder.

Dear Mr. / Mrs. é é é é é é é é é é é é Dateé é é é . /é é é /é é é .

1. INTRODUCTION

You are invited to volunteer for a research study. This information leaflet is to help you decide if you would like to participate. Before you agree to take part in this study you should fully understand what is involved. If you have any questions, which are not fully explained in this leaflet, do not hesitate to ask the investigator. You should not agree to take part unless you are completely satisfied about all the procedures involved.

2. THE NATURE AND PURPOSE OF THIS STUDY

The aim of this study is to understand the views, perceptions and practices of occupational therapists in determining work capacity/incapacity of clients suffering from major depressive disorder (MDD). This is a follow-up investigation of the results of a questionnaire that was distributed amongst occupational therapists working in the field of vocational rehabilitation. By doing so I wish to get a better understanding of how and why occupational therapists use certain evaluation methods, especially when working with clients suffering from MDD.

3. EXPLANATION OF PROCEDURES TO BE FOLLOWED

If you are willing to participate, you will be a member of the focus group. The questions in the focus group interview will relate to the findings of the questionnaire survey, which are attached to the end of this leaflet. The focus group interview will take approximately two hours of your time at a venue that has been mutually determined. The focus group interview will be audio-taped. The data will be used in such a way that you will not be recognised.

4. RISK AND DISCOMFORT INVOLVED

There are no known risks for participating in the focus group interview. You need not respond to any questions that make you feel uncomfortable.

5. POSSIBLE BENEFITS OF THIS STUDY

The benefits to you in participating in the study could be:

- clarifying the procedures of performing functional capacity evaluation with clients suffering from MDD.
- helping to reduce disagreement amongst occupational therapists about the evaluation of clients who suffer from MDD.

6. If you do not want to participate in this study, you will still receive feedback about the outcome of the study if interested.

7. You may at any time withdraw from this study without giving any reasons.

8. HAS THE STUDY RECEIVED ETHICAL APPROVAL?

This protocol was submitted to the Faculty of Health Sciences Research Ethics Committee, University of Pretoria and written approval was granted by that committee. The ethics clearance number is S34/2007. The study has been structured in accordance with the Declaration of Helsinki (last update, October 2000), which deals with the recommendations guiding doctors in biomedical research involving human/subjects. A copy of the Declaration may be obtained from the investigator should you wish to review it.

9. INFORMATION

If you have any questions concerning this study, you are welcome to contact: Mr Enos Ramano, Tel: 011-8497373 or cell 0825742720 or e-mail: ramano@accessweb.co.za.

10. CONFIDENTIALITY

All records and responses obtained during this focus group interview will be regarded as confidential. Results will be published or presented in such a manner that participants and institutions will remain unidentifiable.

11. CONSENT TO PARTICIPATE IN THIS STUDY.

I have read and understood the above information before signing this consent form. The content and meaning of this information have been explained to me. I have been given opportunity to ask questions and I am satisfied that they have been answered satisfactorily. I understand that if I do not participate it will not alter my management or relationship in any way. I hereby volunteer to take part in this study.

I give consent to be audio-taped during this study:

Yes No

I have received a signed copy of this informed consent agreement.

é é é é é é é é é é Participantôs name	é é é é é é é é Signature	é é é é é é é .. Date
é é é é é é é é é é é Person obtaining consent	é é é é é é é é Signature	é é é é é ... Date
é é é é é é é é é é . Witness	é é é é é é é é Signature	é é é é é é Date

We sincerely appreciate your help.

Yours truly

Enos Ramano

Focus Group Interview Guide

Demographic information

0.1 Participant no: (to be completed by the researcher)

0.2 Gender:

0.3 Age: | Male | | Female | | _____ years

0.4 Place of work:

Private Practice ☐	Private Clinic ☐	Insurance/Consultancy ☐
School ☐	University ☐	Company ☐
Provincial Hospital ☐	Rehabilitation Centre ☐	Other (specify) ☐

0.5 Province of work:

Gauteng ☐	Western Cape ☐
Mpumalanga ☐	KwaZulu-Natal ☐
Limpopo ☐	Other (specify) ☐

0.6 Any postgraduate qualification?

Yes ☐ No ☐

0.8 If Yes, year obtained:_____ Name of postgraduate qualification: _____

0.8 Speciality: _____

0.9 Years of experience: _____

Themes for discussion

1. Work capacity

If you think about the role of the occupational therapist in determining the work capacity of clients suffering from major depressive disorder, what comes to mind?

2. Work incapacity

Which factors will you take into consideration to declare such clients as unable to work?

3. Malingering

Do you sometimes find that clients suffering from a major depressive disorder pretend that they are ill in order to avoid returning to work?

4. Personality disorders

To what extent do you think an additional Axis 2 diagnosis (personality disorder) will influence a clientôs work capacity and ability to return to work?

5. Practices of occupational therapists

What do you perceive or view as a good occupational therapy practice in determining work capacity with clients suffering from major depressive disorder? Is it possible to give some specific criteria for a good occupational therapy practice?

6. Steps to determine work capacity

Occupational therapists use different steps to determine work capacity with clients suffering from major depressive disorder. How will you describe the steps that you think a competent occupational therapist should follow to perform a quality type of functional capacity evaluation?

Appendix 4: Ethical clearance certificate

Attached Ethical Clearance Certificate

100 1908 - 2008

UNIVERSITEIT VAN PRETORIA
UNIVERSITY OF PRETORIA
YUNIBESITHI YA PRETORIA

Faculty of Health Sciences Research Ethics Committee

Date: 28/05/2008

Amendment:
- **Title change**
- **Addition of Participant Information Leaflet / Informed Consent Document (Appendix 2)**

Number : **S34/2007**

Title : Perceptions and practices of occupational therapists in determining work capacity of employees suffering from major depressive disorder MDD

Investigator : E M Ramano, Department of Occupational Therapy, University of Pretoria
(SUPERVISOR: D CASTELEIJN)

Sponsor : **None**

This Amendment has been considered by the Faculty of Health Sciences Research Ethics Committee, University of Pretoria on 27/05/2008 and found to be acceptable.

Dr AG Nienaber	(female)BA(Hons) (Wits); LLB; LLM (UP); Dipl.Datametrics (UNISA)
Prof V.O.L. Karusseit	MBChB; MFGP (SA); M.Med (Chir); FCS (SA)
Prof J A Ker	Deputy Dean University of Pretoria
Prof M Kruger	CHAIRPERSON (female) MBChB.(Pret) M. Med.Paed.(Pret) M. Phil. (Applied Ethics) (Stell.bsch) PhD.(Leuven)
Dr N K Likibi	MBChB.; Med.Adviser (Gauteng Dept.of Health)
Snr Sr J. Phatoli	(female) BCur (Et.Al); BTech Oncology
Dr L Schoeman	(female) BPharm, BA Hons (Psy), PhD; Dip. International Research Ethics (UCT)
Mr Y Sikweyiya	MPH; Master Level Fellowship in Research Ethics; BSC (Health Promotions) Postgraduate Dip in Health Promotion
Dr R Sommers	SECRETARIAT (female) MBChB; M.Med (Int); MPhar.Med
Prof C W van Staden	MBChB; M.Med (Psych); MD; FTCL; UPLM
Prof TJP Swart	BChD, MSc (Odont), MChD (Oral Path)
Dr AP van der Walt	BChD, DGA (Pret)

Student Ethics Sub-Committee

Prof R S K Apatu	MBChB(Legon); PhD(Cambridge); PGD International Research Ethics (UCT)
Dr A M Bergh	BA , BA (Hons) (Linguistics), BA (Hons) (German), BEd, PhD, SED
Mrs N Briers	(female) BSc(Stell), BSc (Hons) (Pret),MSc (Pret) DHETP (Pret)
Dr S I Cronje	BA; BD; DD (UP) – Old Testament Theology
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SECRETARIAT of the Faculty of Health Sciences
Research Ethics Committee
University of Pretoria

DR L SCHOEMAN; BPharm, BA Hons (Psy), PhD;
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CHAIRPERSON of the Faculty of Health Sciences
Student Research Ethics Committee, University of Pretoria