Client perceptions of social skills development occupational therapy intervention groups in an acute psychiatry setting

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I, Mrs Andrea Radnitz, declare as follows:

1. That the work described in this thesis has not been submitted to UKZN or other tertiary institution for purposes of obtaining an academic qualification, whether by myself or any other party.
2. That my contribution to the project was as follows:
I designed and prepared the proposal, funded and conducted the research, transcribed and analysed the data and constructed the articles and thesis documents under the guidance of my supervisors.
3. That the contributions of others to the project were as follows:
No other people had significant intellectual contributions to this study.

Signed _____ Date_____

Pre-amble:

This document is written in the format of a “Masters by manuscript”, as per the requirements of the University of KwaZulu-Natal’s research office. The transition away from “Masters by dissertation” has been made in 2017, by the University of KwaZulu-Natal, in order to encourage students to publish their work, thereby, making more of the research conducted for degree purposes accessible to the public, to aid in the transfer of knowledge. The university’s formatting requirements can be found under attachment A. The research articles have been referenced according to the guidelines of the journals to which they will be submitted. The rest of the document, for consistency, has been referenced according to the guidelines of the second journal article; an adapted Harvard referencing system. These guidelines can be found in Appendix J

Dedication:

To my Lord and Father, Jesus Christ.

Acknowledgements:

I would like to acknowledge Abigail Foley and Margaux D’Hangest D’Yvoy who gave willingly of their time to conduct the focus groups. I thank my supervisors who both went out of their way to support and encourage me despite the pressures in their own lives. I am indebted to my husband and my sons who have made it possible for me to complete this study, through their encouragement and support, and by graciously giving me space to work. Finally my thanks go to the many colleagues who have shared their wisdom and insight into this study and our clients who so enthusiastically participated.

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List of Abbreviations:

MHCU……Mental health care user

List of operational definitions:

Interpersonal relationships: This refers to the relationship between two individuals. The well-being of this relationship can be influenced by many inter- and intrapersonal factors.

Social skills: This refers to the set of skills an individual holds, with which they communicate and relate to other people. These skills include the ability to communicate, both verbally and non-verbally, listen effectively, and manage conflict effectively.

CLIENT PERCEPTIONS OF OCCUPATIONAL THERAPY INTERVENTION GROUPS IN AN ACUTE PSYCHIATRIC SETTING:

CHAPTER 1: INTRODUCTON

1.1 INTRODUCTION

Occupational therapy is deeply rooted in mental health care, especially in the treatment of hospitalised or institutionalised clients (Paterson, 2008). Despite this long history and the continued, regular use of this therapeutic mode in current practice, research in this area is currently severely limited (Cowls and Hale, 2005; Occupational Therapy Association of South Africa, 2014; Scanlan, Argent, Ayling, Mouawad and Woodward, 2015).

1.2 BACKGROUND

This study developed out of the frustration of looking for evidence on which to base practice as a group work occupational therapist, and finding very limited information. This dearth of information impacts on occupational therapists ability to choose the most effective interventions and make effective choices of group structuring and handling principles. . I believe that if we as occupational therapists want to keep our role in the treatment of MHCU's then we need to firstly, better understand and grow its value, and secondly, we need to prove to other professionals that our work has worth. This thought was then confirmed as I started reading articles and literature, where I discovered many calls to research and thoughts that concurred with and expanded my own (Lloyd, and Williams, 2010). I could not expect other therapists to do this work if I was not prepared to contribute myself. This study comes as a result of this conviction.

After some reading it was apparent that it would be difficult to quantify the efficacy of group therapy intervention, and so the study would need to be a qualitative one. Although clients do not always have emotional insight into their difficulties and the impact of each intervention, they are able to tell their own stories and comment on the

functional changes that they have made as a result of intervention. The clients' perceptions impact on their investment in therapy and their treatment compliance and are therefore useful in starting to understand the impact of occupational therapy groups and altering group therapy to strengthen clients' investment in treatment.

In both the global and the South African context mental illness is a growing concern, and using resources efficiently in the treatment of these disorders is becoming critical.

Occupational therapists cover many topics and areas during group intervention with MHCUs. To study all of these in this study would make the data to broad or the study too large. To gain more depth of insight and make the data size manageable a particular area of intervention needed to be chosen. As Literature shows Interpersonal relationships play an important role in mental health and human development (Baron, Branscombe, & Byrne, 2009; Cassidy, 2002; Yalom & Leszcz, 2008) and mental health problems impact on the clients' interpersonal relationships (Buist-Bouwman et al., 2006) the study was initiated in this area.

1.3 STUDY CONTEXT

The study was set in KwaZulu-Natal, South Africa, in an acute private psychiatric clinic that provides voluntary inpatient care for adults with general psychiatric disorders. The majority of the clients admitted to the facility are members of a medical aid or medical insurance plan which covers the expenses incurred by the admission. A few clients pay their medical expenses personally. The three-week treatment plan includes occupational therapy groups, psychology groups, and individual consultations with psychologists and psychiatrists. The 21-day group programme is structured around three themes, interpersonal relationships, self-awareness and emotional management, with each theme taking one week. There are a total of 25 therapy groups offered during the week Clients are strongly encouraged to attend most groups, but are often called out of the group programme for individual consultations with doctors and psychologists. The programme is relatively consistent

with planned groups and activities, but is sometimes adapted for special occasions or public holidays and particular groups' needs.

1.4 PROBLEM STATEMENT:

Occupational therapists need to be able to provide effective and efficient therapy to MHCUs. To do this they need a greater understanding of how the MHCUs perceive occupational therapy groups and what techniques and tools make a significant impact on the clients daily functioning, particularly in terms of interpersonal relationships, which have a broad impact on clients functioning in many areas of their daily functioning. Further a deeper understanding of occupational group work is vital to providing an effective service.

1.5 RESEARCH QUESTION

What are client perceptions regarding occupational therapy intervention groups which facilitate the remediation or strengthening of interpersonal relationships at the study site? Furthermore, what are the clients' perceptions regarding the efficacy, applicability, and meaningfulness of the group content?

1.6 RESEARCH AIM

The aim of this research project was to investigate and describe the inpatient clients' perceptions of occupational therapy intervention groups in terms of their efficacy in the facilitation and strengthening of clients' interpersonal relationships.

1.7 RESEARCH OBJECTIVES

1. To explore the participants' interpersonal relationships and to understand how any interpersonal difficulties are related to their mental health.

2. To describe how clients' perceptions of their relationships and interpersonal styles have developed as a result of group therapy, and if, or how, the clients' social skills repertoire has been strengthened. Furthermore, to describe clients levels of confidence in using their social skills to remediate or strengthen their relationships.

3. To explore clients perceptions of which occupational therapy groups or exercises were effective in strengthening their social skills repertoire and which groups or exercises were deemed to be less effective or ineffective.

4. To explore clients' experience of group therapy, the groups' levels of cohesion, trust and openness, focusing on Yalom's 11 principles, to discover how being a group member impacted on members' abilities and opportunities to practice and strengthen their social skills.

5. To identify gaps in the group content or process where clients still experience a lack of, or unresolved difficulties with regard to their social skills repertoire and to explore clients' experiences of the order of the groups presented, the structure of the groups and their suggestions, advice, and recommendations for the group content, presentation and format.

1.8 LITERATURE REVIEW

An initial search for literature pertaining to occupational therapy group work, in acute psychiatric settings was conducted in google scholar, a few relevant articles where found and the relevant references of these articles were searched for further information. The search was broadened to Pubmed, Wiley online library and Sage journals once the researcher had access to the university library.

1.8.1 Occupational therapy in mental health care

From as early as 1922 the philosophy of improving client's mental health through participation in meaningful activities was described in literature (Meyer, 1922). This has become the underpinning philosophy for contemporary occupational therapy intervention, and continues to guide occupational therapists thinking and practice (Patterson, 2008). The occupational therapists' role in the treatment of mental health care users (MHCU) remains an important one, despite the many changes and challenges in the present-day mental health care systems (Patterson, 2008; Smith and Mackenzie,2011; McMorris, 2017).

Occupational therapists play a key role in inpatient care, from admission to discharge. The four core elements of occupational therapy practice, in adult acute mental health settings, are: individual assessment, therapeutic groups, individual treatment and discharge planning (Lloyd, *et al.*, 2010). The focus of this study is on the third core element, that is, therapeutic groups. Despite group work being a core element of occupational therapy intervention in mental health, there is currently limited research on these groups (Cowls, *et al.*, 2005; Sporild and Bonsaksen, 2014). There is however, extensive evidence on the efficacy of group therapy from the field of psychology (Yalom and Leszcz, 2005).

Occupational therapists use participation in meaningful activity to promote healing (Law, 2002), based on the philosophy that purposeful, meaningful activity or occupation has value and can give a sense of self-efficacy and self-esteem (Trombly, 2014). The use of occupation in a social environment can assist clients in achieving self-actualisation, developing clients' self-esteem and confidence (Rebeiro and Cook, 1999). Some of the activities included in occupational therapy intervention groups with MHCU include: art, music, movement, role play, sport, activities of daily living, games, and leisure (Duncan and Prowse, 2014; Nott, 2014; van Greunen, 1997). Most occupational therapists working in mental health care regularly use creative activities (Craik, Chacksfield, & Richards, 1998), such as crafts as these help to anchor clients in the here and now, and can be used to influence the clients' thoughts and emotions (Perrin, 2001). Occupational therapists combine the powerful benefits of participation in occupation with the benefits of group therapy during occupational therapy intervention groups.

Recently healthcare has made a significant shift towards evidence-based practice. Evidence-based practice assists clinicians to offer the most appropriate and efficient service to clients while considering the clients' values and needs (Upton, Stephens, Williams, and Scurlock-Evans, 2014).

Occupational therapists have started working towards evidence in our practice, through researching and documenting what we have seen in our practice, and proving that participation in meaningful activity is therapeutic. Despite this progress, there are still significant gaps in our evidence and in our knowledge of best-practice in the area of mental health care (McMorris, 2017). It is important that therapists have access to research on best group work practice, hence underpinning the need for this study.

One of the studies that has started the process of building evidence for our practice is a study conducted in an acute inpatient setting in Canada, by Cowls and Hale (2005), on what clients' value in occupational therapy groups. This qualitative pilot-study, based on the interviews of eight participants, found that clients value participation and activity. Not only did the clients prefer activity-based groups to verbal groups, but they also demonstrated a greater improvement in skills after attending activity-based groups. Their clients valued topic related warm-ups and activities, and repetition of information as retention is impacted negatively by anxiety. Their clients had a mixed response to skills teaching, with all but one client finding it valuable. Furthermore clients valued group cohesion and support from other group members, both inside and outside of the groups, and found hearing others' experiences beneficial. Several clients appreciated anger management and assertiveness training and wanted more of this in the programme, however, others found it overwhelming. This study was a pilot study that used a very small sample size and was only conducted at one site in Canada, which limits the generalizability to Southern Africa due to our vastly different cultural and socio-economic climate. It will add to the generalisability of both studies if the results are similar.

Despite this literature review showing that group therapy has been an integral tool in the treatment of MHCUs in acute facilities and the significant increase in the occurrence of mental illness, this is the only study found in literature based on this population and their perceptions' of group therapy. This is a travesty, and demands an urgent response of further study of such a vital and far reaching global need.

1.8.2 Mental health problems are a significant and growing concern

On the global level, mental health disorders are a significant and growing concern, with unipolar depression alone being predicted to be the second highest contributor to the global burden of disease by 2020 (Murray and Lopez, 1997). This growing burden in conjunction with the current trend of shorter hospital admissions pressurises occupational therapists to make our treatment as effective as possible (Cowls, *et al.*, 2005). This study is designed to contribute to the effort to produce research studying client satisfaction with occupational therapy services and was aimed to explore the value of group therapy in the clients' perspective and improve the services offered in order to effectively treat clients with mental health difficulties.

On the national level, South Africans live in a context of violence, rape, abuse, increasing crime, escalating HIV infections, high male infidelity, dispersed families, high unemployment rates and financial strain (Wojcicki, 2002; Hölscher, 2008; Gibson, 2012; Harrison, Cleland and Frohlich, 2012; Bennett, Hosegood, Newell and McGrath, 2015). Research shows that some of the risk factors for mental health disorders are severe early life stress, abuse, neglect and separation from either parent during childhood, lower childhood socio-economic background, financial strain, isolation and stressful life circumstances, as well as poor perceived physical health (Chan and Zeng, 2011; Eriksson, Räikkönen, and Eriksson, 2014). Many of the risk factors for mental health problems are entrenched in the current South African socio-economic climate, resulting in many clients with mental health difficulties and very limited access to treatment. This necessitates not only effective therapy but treatment that is efficient in terms of resources such as therapist time and clients' medical aid benefits.

1.8.3 Interpersonal relationships and mental health

Interpersonal relationships play an important role in mental health and human development (Dozier, Stovall, and Albus, 2002; Yalom, *et al.*, 2005; Baron,

Branscombe, and Byrne, 2008). Literature shows that mental health problems impact on the clients' interpersonal relationships (Zlotnick, Kohn, Keitner, Della and Ba, 2000; Hammen, and Brennan, 2002; Buist-Bouwman, De Graaf, Vollebergh, Alonso, Bruffaerts and Ormel, 2006) and on their ability to perform their activities of daily living (Buist-Bouwman *et al.*, 2006).

Research has shown that woman with depression have interpersonal discord which then contributes to stressful life events, leading to exacerbated symptoms of depression in both themselves and their offspring (Hammen, Shih and Brennan, 2004). These maladaptive interactions include dependence on others, seeking reassurance in ways that distance others, and relying on others for a sense of self-worth (Hammen *et al.*, 2002). The significant impact of interpersonal difficulties on the individual and on their social systems (Hammen *et al.*, 2002) makes the treatment of social competence and enduring family discord important in treating depression (Hammen *et al.*, 2004).

1.8.4 Group work

1.8.4.1 Benefits of group work

Although there is limited research on occupational therapy groups in mental health, there is extensive literature on the significance of group therapy from the field of psychology. Group therapy is a significant aspect of mental health intervention and has been shown to have many benefits to clients with mental illness (Yalom, 1983; Finlay, 1993; Duncan, 2014; Yalom *et al.*, 2005; Corey, Corey and Corey, 2008). According to Yalom and Leszcz, group therapy is an effective form of therapy and is at least equal to individual psychotherapy in its power to provide meaningful benefit (Yalom *et al.*, 2005). The fact that group therapy is effective and makes good use of limited resources makes it a vital tool in mental health.

Yalom (1983) explored why group therapy has such a significant impact. He proposed eleven therapeutic factors which are inherent in group therapy and increase its value. These factors include the instillation of hope, universality, imparting of information, altruism, corrective recapitulation of the primary family group, development of socialising techniques, imitative behaviour, catharsis, existential factors, cohesiveness and interpersonal learning.

1.8.4.2 Group works relevance to interpersonal relationships

Yalom (1983) asserts that the group acts like a social microcosm, meaning that both maladaptive and adaptive behaviours, in the group are reflective of larger patterns of behaviour outside of the group. Through group therapy then, people with disordered interpersonal relationships are able to develop more adaptive and gratifying relationships. This is achieved by understanding how they relate to and impact on other group members. Through the opportunity to practice and receive feedback group members are able to improve social skills and develop more meaningful interpersonal relationships. Yalom (2005) describes how the therapeutic factor 'interpersonal learning' assists clients within groups to experience a 'corrective emotional experience'; this is the healing through experiencing meaningful interactions' within the group that disconfirms the clients' pathogenic beliefs.

Madeleine Duncan (1997, p. 266) summarises the value of group therapy when she says: "The group experience is primarily used in Occupational therapy to help the client gain more appropriate intra- and interpersonal behaviours."

1.8.4.3 Defining occupational therapy group work:

The position statement on therapeutic group work in occupational therapy describes occupational therapy groups in terms of four criteria. Occupational therapy groups address dysfunctional occupational performance areas, in mental health care; social participation is often a key area of difficulty. Occupational therapy groups have clear goals and these are achieved through the use of activity, task or occupation which

supported through the use of appropriate, intentional questions to assist the clients to reflect on the process (Occupational Therapy Association of South Africa, 2014).

1.9 SIGNIFICANCE AND RATIONALE

This study has particular significance for occupational therapists working in acute mental health settings, however, it may also be of interest to other therapists working through the medium of group work. The second article in particular describes group techniques and structure that could be applicable to many therapists running groups with clients in the acute phase of treatment. As this is a qualitative study, it gives therapists a glimpse into groups from the perspective of the client, and as a result, may assist therapists to deepen their levels of understanding and gain a more client-centred approach.

1.10 METHODOLOGY

1.9.1 Research Design

Qualitative research is useful in answering open-ended questions, such as how people experience events (Terre Blanche, Kelly and Durrheim, 2006; Willig, 2013). A qualitative design was used for this study as it allowed for rich and in-depth study (Patton, 2002; Mack, Woodsong, MacQueen, Namey, and Guest, 2005), as this was necessary for answering the question of how participant s perceive occupational therapy groups.

An exploritative and descriptive design was used in the study. The use of this design was important due to the dearth of research on this topic in the Southern African context the relevant themes and ideas needed to first be described and unearthed. Denzin and Lincoln described research at this level needing to be from a interpretative and naturalist approach in order to understand phenomena and what meaning participants' bring to them (Denzin and Lincoln, 2000)

1.9.2 Population

The clients at the study site are divided into 2 units, the general unit, and the dual diagnosis unit. Clients from the general unit formed the population for this study. Clients from this unit are admitted to hospital for the treatment of mental health disorders that are not co-morbid with any substance abuse. Common diagnoses include, but are not limited to, major depressive disorder, post-traumatic stress disorder, bi-polar mood disorder, and general anxiety disorder. The population tends to be predominantly female clients of all races and ranges in age between 18 and 75 years. The total population size varies but is usually between fifteen and forty patients.

1.9.3 Sampling Strategy

The sample was accessed through the use of purposive sampling. This non-probability sampling technique is often used in clinical research where participants meeting the inclusion criteria are selected to participate in the study (Mack, *et al.*, 2005; Acharya, Prakash, Saxena and Nigam, 2013). The inclusion criteria were as follows:

- Participants must have been an inpatient during the week of the research.
- Participant s must have attended at least seventeen of the twenty-five therapy groups during the week.
- Participant s had no active psychosis for at least 7 days prior to the focus group.
- The participant had been a member of the higher functioning general unit group.

The third inclusion criterion, around the number of groups attended, was included to ensure that participants had a relatively thorough understanding of the groups presented so that they can give accurate comment on the progression and content of the groups. This criterion had to be abandoned before the first focus group, as the population was small at the time, with only three of the participants meeting this criterion Exclusion of all but three of the participants would have taken much valuable data from the focus group. Although this did impact on some of the participants' ability

to comment on the fullness of the group programme, it added to the richness of the data as it afforded an opportunity to compare participant s who attended the more groups to those who had not. After the withdrawal of this criterion participants had attended between five and twenty-three groups, of a maximum of twenty-five groups during the week of the focus group.

1.9.4 Data collection

Focus groups were chosen as a means of data collection as they increase the quality and depth of the data obtained. The group process allows participants to be stimulated by others' ideas, and to explore their own perceptions and views through interaction with others. Due to these benefits focus groups have been used extensively to study peoples' understanding of disease and health services (Kitzinger, 1995; McMillan and Schumacher, 2006). Focus groups are effective as they are non-threatening, and helpful in obtaining people's perceptions (Ogunbameru, 2003; Marczak and Sewell, 2013; Krueger and Casey, 2014). The data was collected over a four-month period, through the use of a series of four 60 to 90-minute focus groups, one after each 'interpersonal relationships' themed week, run on a Friday late afternoon, after the conclusion of the group programme.

The entire general unit population was invited to join the study by the researcher, at the end of one of the occupational therapy groups. They were clearly informed of the aims, and that their participation was entirely voluntary and their decision not to participate would not impact on their further treatment in any way. Participant s were offered an information sheet, detailing all of this information. The group was reminded of the study on the day of the focus group. The individuals who had not met the inclusion criteria were offered refreshments, thanked, and excused from the focus group. Refreshments were offered at the start of the focus groups while the paperwork was being executed, to assist the participants to feel comfortable and to thank them for their participation in the study. The participants were asked to fill out an informed consent form, which included permission that the participant be audio recorded during the focus group. They then filled out the demographics form and a

request for feedback form was also circulated for those who wanted feedback on the outcome of the study. The focus group was conducted by a facilitator (clinical psychologist) and a research assistant (occupational therapist). The researcher herself did not conduct the focus groups as she was one of the group therapists working at the site at the time, and a therapist's presence in the group may influence the participant s to be less critical out of a desire to please their therapist or out of fear of repercussions. Both the focus group facilitator and the research assistant had worked at the study site in the past and so were very familiar with the group programme and the study site itself. The focus group facilitator followed an interview schedule (Please see appendix B for the semi-structured questions), which was constantly applied across the focus groups. The interview schedule was designed by the researcher to prompt participants to describe where their relationships had been prior to treatment and compare this to the changes, if any, as a result of the intervention. As this is an acute unit, the entire population is discharged and replaced by new group members over a three week period; each focus group was run with participants willing to participate during the time of their admission.

The focus groups were audio recorded by the research assistant and who also wrote down some of the content with each speaker's pseudonym and significant body language to assist with accurate transcription.

For a study to be considered trustworthy four strategies need to be considered, that is credibility, dependability, confirmability, and transferability (Houghton, Casey, Shaw and Murphy, 2013). Credibility refers to the truth, value and believability of the findings (Shenton, 2004; Cohen, and Crabtree, 2006; Greenwood and Levin, 2007). The research feedback is valuable in adapting and deepening the therapeutic process and programme at the study site. Credibility was ensured through prolonged engagement, analyst triangulation, and negative case analysis. Prolonged engagement makes a study more trustworthy through the researcher having a greater overview of the population and not just a snapshot at the time of the study. As the researcher works in the setting where the research was conducted she has prolonged

engagement with the setting and topic. The fact that the researcher is employed at the site could allow for researcher bias to influence the study outcomes. This has been managed through the use of reflexivity and transparency in the research process. The first level of reflexivity was done through reflection on the data during the transcription process, with the researcher reflecting on her feelings and responses to the raw data. Regular, open conversations with the focus group facilitator, research assistant and supervisors assisted in a second level of reflexivity as the data was coded and themes developed.

Analyst triangulation was done through conversations about the grouping and coding of data with the supervisors. The focus group facilitator and supervisors were asked to check the transcripts and read the articles to check if they believed that it was an accurate reflection of what the participants had said.

As the researcher is a therapist working on the unit, she did not conduct the focus groups. Both of the facilitators who conducted the focus groups had previously worked at the facility and had a good idea of the programme and the study site. Unfortunately, one of the participants was seen by this psychologist for individual therapy, and the facilitator also filled a locum position for a few groups before one of the focus groups, this may have biased the data, any apparently biased comments around this facilitators groups have been excluded from the data.

Negative case analysis concerns the act of giving attention to, not only the cases that fit the explanations, but also understanding those that don't (Mays and Pope, 2000). Participant s' thoughts that did not agree with the majority have been reported on in this study so that a complete unbiased voice is heard from the participant s. Four focus groups were conducted so that saturation could be achieved. Gaining four sets of participant s' ideas and perceptions, helped to identify if perceptions are consistent across the population or only isolated thoughts.

Analyst triangulation was done through the inclusion of one of the research assistants and the supervisors of this study in conversions around the data analysis and understanding of themes and reading of the articles. Peer debriefing: the study, particularly the transcripts, coding, thematic analysis and final report were discussed with neutral peers to highlight any alternative explanations of the data (Spillett, 2003; Kielhofner, 2006).

The concept of transferability refers to the researcher's responsibility to offer a thick description of the setting of the research and the researchers' field experiences so that readers are able to decide if the information gained would be transferred as useful in the reader's context (Cohen *et al.*, 2006; Houghton *et al.*, 2013). Direct quotes from the data have been included in the report. A description of the clinic setting and a rich description of the participants allows other therapists and researchers to identify whether the findings would match with their population.

Dependability refers to how stable the data is, as well as to strategies that assist to confirm dependability, such as an audit trail and reflexivity (Houghton *et al.*, 2013). Dependability in this study was ensured through offering a clear explanation of decisions made in the data gathering, analysis processes and reflection, and description of how the researcher's ideas and circumstances impacted on these decisions. Confirmability refers to how neutral and accurate a data set is (Houghton *et al.*, 2013). The same processes were used for confirmability as for those of dependability.

Power differential: in order to prevent a power differential the participant s were given no indication that the researcher had any desire for the findings to reflect in a positive way or that the groups or therapists themselves were under any scrutiny.

1.9.4 Participants

Twenty-five participant s between the ages of 18 and 50 years old participated in the study, which included twenty females and five males. This gender imbalance is

typical of the distribution of the participant s within the study population. In order to protect confidentiality and ensure anonymity, each participant was given a participant number and then a pseudonym, congruent with their gender and culture.

Of the 25 participants eight were English home language speakers, 13 spoke IsiZulu, and four spoke isiXhosa. At the time of the study 17 participants were employed on a full-time basis, one was self-employed, one in part-time employment, one was unemployed, three were currently studying and one was a grade 12 learner. The last participant did not fill in the answer to this question. For 20 of the participants this was a first admission, four participants reported that this was their second or third admission. One participant reported that she had been admitted more than six times, the researcher queried the accuracy of this response for her knowledge of the participant and the participant s age, this may have been a response error. At the time of the study 14 of the participants considered themselves single, one in a relationship, six were married, one widowed and three divorced.

Table 1.1 Focus groups Participants:

Participant Number	Article pseudonym	Age	Gender	Home language	Marital status	Number of mental health in-patient admissions (inclusive)	Number of groups attended in the week	Highest level of education	Current Employment status
Focus group 1									
P1	Bandile	26	m	IsiZulu	Single	1	22	Gr 11-12	Part-time employment
P2	Ayanda	29	F	IsiZulu	Single	1	19	Post-grad studies	Full-time employment
P3	Anne	30	F	English	In a relation-ship	1	16	Gr 11-12	Full-time employment
P4	Cath	30	F	English	Divorced	1	14	Gr 11-12	Full -time employment
P5	Khanyi	22	F	IsiZulu	Married	2	12	Not yet graduated	Currently studying
P6	Grant	24	m	English	Single	1	16	Gr 11-12	Full-time employment
P7	Londi	18	F	IsiZulu	Single	*6 or more	20	Gr 8-10	Currently studying
P8	Mpume	25	F	IsiZulu	Single	1	5	Gr 11-12	Full -time employment
Focus group 2									
P10	Peter	41	M	English	Married	1	23	Gr11-12	Self-employed
P11	Mandla	50	M	IsiZulu	Divorced	1	16	Post-grad	Full-time employment
P12	Menzi	34	M	IsiXhosa	Single	1	13	?	Currently studying
P13	Pt was called out at the start so did not part.								
P14	Musa	37	M	IsiZulu	Single	1	23	Not yet graduated	Full-time employment
P15	Sarah	36	F	English	Married	1	18	Gr11-12	Full-time employment
Focus Group 3									

Participant Number	Article pseudonym	Age	Gender	Home language	Marital status	Number of mental health in-patient admissions (inclusive)	Number of groups attended in the week	Highest level of education	Current Employment status
P16	Nandi	30	F	IsiZulu	Single	1	19	Tertiary education	Full-time employment
P17	Buhle	31	F	IsiZulu	Single	3	10	Gr11-12	Full-time employment
P18	Julie	41	F	English	Married	1	22	Gr11-12	Full-time employment
P19	Fikile	28	F	IsiXhosa	Divorced	2	15	Tertiary education	Full-time employment
P20	Zanele	30	F	IsiZulu	Single	1	11	Tertiary education	Full-time employment
P21	Zodwa	30	F	IsiZulu	Married	1	11	Gr11-12	Full-time employment
P22	Noma	30	F	English	Single	1	8	Tertiary education	Not employed
Focus group 4:									
P24	Thandiwe	31	F	IsiXhosa	Single	2	5	Tertiary education	
P25	Janet	18	F	English	Single	1	18	Gr11-12	Learner
P26	Wandile	34	F	IsiXhosa	Single	1	17	Not yet graduated	Full-time employment
P27	Sné	45	F	IsiZulu	Married	1	18	Tertiary education	Full-time employment
P28	Sibongile	50	F	IsiZulu	Widowed	1	12	Tertiary education	Full-time employment

Note: all names used in the table are pseudonyms.

Note: The participant numbers are not consecutive, due to participants being called out at the beginning of the focus group to see doctors and for ease of numbering. There is no P9, or P23 and P 13 was called out, this leaves 25 actual participants.

* Researcher queries the accuracy of this response.

1.9.5 Data Analysis

After data collection, the recordings were transcribed by the researcher herself. This transcription was checked against notes taken down by the research assistant during the focus group to ensure accurate transcription and improve credibility. The transcriptions were audited by research supervisors to ensure accurate transcription.

Thematic analysis, using a realist approach, was used to analyse the data. Thematic analysis is a technique used to organise, analyse and report themes or patterns within a data set. Thematic analysis was chosen as it produces a rich, and complex understanding of the data, and is useful in understanding participants' emotional experiences (Braun, and Clarke, 2006; Saldana, 2015). A realist approach allows language to be understood as a means to communicate meaning and experience; this means that the data was understood as it was expressed without adding layers of hidden agendas or motivations (Braun, *et al.*, 2006). Inductive thematic analysis was used to identify themes in the data. Inductive analysis is driven by the data, allowing the data to be grouped into codes and themes without a preplanned coding matrix (Braun *et al.*, 2006).

The aim of data analysis was to clearly understand participant s' perceptions of all areas of occupational therapy groups through organising the data into clear themes. After the initial transcription, the data was coded, by typing words or phrases summarising the statement, alongside each comment. The codes where then studied to identify themes but printing the material and dividing the codes into themes and sub theme. This allowed the researcher to group and regroup codes until they made the most sense. These themes were then reviewed, defined and finally reported (Braun *et al.*, 2006; Saldana, 2015).

1.9.6 Ethical Considerations

Ethical approval was gained from the UKZN Humanities and Social Science Research Ethics Committee (Approval number _BE208/16_) as this study was conducted with a vulnerable population. Permission to conduct the study was also

obtained from the gatekeepers of the clinic, at both a local and national level. There are four principles to consider in biomedical research ethics. These are respect for persons, beneficence, justice, and respect for communities (Mack *et al.*, 2005) and these principles underpinned my research.

With regard to respect for persons, the participant's autonomy and confidentiality were respected through the completion of a detailed consent form (available in either English or isiZulu) in which the aims and procedures of the research are described. This included a section explaining that the focus group would be audio-recorded and a section informing them that they could leave the study at any time with no negative consequences. Respect for the individual participant s' was upheld by the focus group facilitator and research assistant during the data collection.

The participant s' confidentiality has been respected by encoding the participant 's biographical information so that their identity is protected. Data has been stored electronically, accessed via a password known only by the researcher and supervisors. The data will be directly fed back to the participant s that requested feedback and to the clinic's therapeutic team so that future participant s can benefit from the study.

Beneficence: the participant s may have benefitted from the study through seeing that their opinions are important and valid and by having offered them an opportunity to be assertive. It may have given them an opportunity to process their group therapy experiences on a different level. The data gained from this study may be used to help therapists gain a better understanding of participant s' perceptions and experiences of group therapy and thus be more understanding and effective as therapists. Secondly, the data gained could assist with development of occupational therapy groups and programmes that are a more positive and effective experience for future clients.

Justice: This study sought to maintain justice as those participant s that were prepared to participate in the focus group had the opportunity to have their opinions and thoughts heard and may have gained benefit from attending the focus group. The data will be directly fed back to the site's therapeutic team so that future clients can benefit from the study.

With regard to respect for community, the report and publication of the data have been written in a way that is respectful to both clients with mental health difficulties and the site population.

Non-maleficence: Risks to the participant s in this study were limited to loss of respect or positive regard from group therapists, this risk was be limited through maintaining confidentiality and through the use of codes for participant 's biographical information on the transcripts and report. This risk was also prevented through the use of external therapists to lead the focus groups.

CHAPTER 2: PRESENTATION AND INTERPRETATION OF FINDINGS

2.1 INTRODUCTION

The findings of this study have been presented in the form of two scientific journal articles. The first “Group therapy as a vehicle to address relationship problems in occupational therapy” discusses how the participant s’ relationships were impacted by the group therapy programme. The second: “The insider perspective: occupational group therapy process and content in an acute mental health facility.” describes the participant s’ perspectives on the group content, techniques, and process.

The themes of the study are laid out in the table below. Themes presented in the table below in purple are discussed under Article 1 and themes represented in blue under article 2.

Table of themes:

Super-Theme	Theme	Sub-theme	Micro-theme	Speaks to objective
Baseline relationship problems	Family linked problems			1
	Participant linked problems			1
	Problems linked to the relational systems			1
	Stigma of mental illness exacerbates problems			1
Occupational Therapy groups intervention	Group Description	Group size		3
		Group therapist		3
		Open groups		3
		Time frame		3
	Group Techniques	General group	Group handling skills	3

		techniques	Warm-ups	3
			Examples and demonstrations	3
			Participation and interaction	3
		Specific group techniques	Craft groups	3
			Relaxation, reflection and role-play	3
	Group Content			3
	Group Process	Group cohesion and norms		4
		Individual therapy verses group therapy		4

I So we were given the skills and applied them	Personal benefits of group work			2
	Family love and support in the groups makes a space to practice skills			2
	Family love and support outside of the group time			2
	Groups helped to develop insight and to evaluate relationships			2
	Responsibility versus blame			2
dema nding now	Direct impact of groups on the participants' relationships			2

	Plans to implement skills in these relationships vs doubts about their ability to do so, impacted by missed groups.			2
	Limitations of group therapy			2

Note objective 5 is discussed under the recommendations section within the articles.

2.2 CONTRIBUTION RECORD

The student conceptualised the papers and was the main author. My supervisors Chantal Christopher and Thavanesi Gurayah contributed towards the writing of these articles.

2.3 PUBLICATION DETAILS: ARTICLE 1

Title: "Group therapy as a vehicle to address relationship problems in occupational therapy"

Author: Andrea Radnitz

Main supervisor: Chantal Christopher

Co-supervisor: Thavanesi Gurayah

Status: to be submitted

2.4 JOURNAL INFORMATION

This scientific journal article was written for publication in the South African Journal of Occupational Therapy. This journal publishes articles with relevance to occupational therapy in Africa. References for this journal must adhere to an adjusted Vancouver system, as described in the journal and must be published in the order that they appear in the article.

2.5 ABSTRACT

Background: This qualitative study set in an acute inpatient psychiatric clinic investigates the efficacy of occupational therapy groups targeting interpersonal relationships, from the participant s' perspective.

Purpose: This study was designed to explore the effect of occupational therapy groups on participant s' interpersonal relationships.

Method: Four, sixty-minute focus groups were used to ascertain the participants' experiences of groups and the effect of these on relationships. These sessions were audio-recorded and transcribed. Thematic analysis was used to analyse the data.

Findings: This article tells the story of the development of the participants' relationships through the journey of attending group therapy, from the initial struggles in their personal relationships, through the development of insight into these difficulties, the learning of skills and problem-solving solutions, to the application of some of the skills and hope for future relationship development.

Three themes are discussed in the article. "We all have relationship problems" outlines the participants understanding of their relationship problems. The second theme "we were given the skills and applied them" describes how group therapy helped them develop further insight and acquire greater relational skills. "I am less demanding now" describes how developing insight and skills have impacted the participants' actual relationships and their hopes for their relationships. Conclusions: Participants gained significant benefit from group work, on both a personal and a relational level. Group therapy provided a safe place to learn and then practice the skills that participants had learnt. The insights gained into adaptive and maladaptive relationships and participants' interpersonal styles through group therapy assisted participants in strengthening their relationships with group members and others. Despite improved knowledge, insight and skills, participants were not always able to use their skills consistently. One factor that improved their confidence to apply skills was consistent group attendance.

2.6 ARTICLE 1

Group therapy as a vehicle to address relationship problems in occupational therapy

Introduction

Mental health difficulties are a pervasive and growing global issue affecting many people across the globe[1]. In 2013 mental and substance use disorders were the leading cause of "years of life lived with disability" worldwide[3:1579] and it is predicted that by 2020 unipolar depression alone will be the second highest contributor to the worldwide burden of disease[2]. This challenges health systems globally and makes the prevention and treatment of these disorders a priority. Effective and efficient therapy in mental health practice, including occupational therapy practice, is hence important on a national and global level.

Occupational therapy has deep historical roots in mental health care, especially in the treatment of hospitalised clients[4]. Group work is one of the core elements of occupational therapy interventions in mental health, and many researchers have emphasised the need for further research in this area[5–8] as there is limited current research to show evidence for practice. In an attempt to contribute to research in this domain, this study was designed to investigate the efficacy of occupational therapy group interventions within an acute in-patient facility programme. These groups were aimed at enhancing the quality of the mental health care users' (MHCUs) interpersonal relationships.

Literature review

The relational difficulties of MHCUs

Interpersonal relationships play a vital role in fostering mental health[9–11]. Research shows that MHCUs have chronic problems such as poor interpersonal skills, difficulty forming relationships, poor social skills, conflicts with authority, dependency, isolation, inability to express and control anger and hypersensitivity to separation[11–14]. Almost all clients admitted

in crisis to an in-patient facility "*suffer from a breakdown or absence of supportive relationships with others*"[11:487]. Mental health problems impact on the clients' social relationships and their ability to perform daily activities[15], making them an important focus of treatment in acute psychiatric facilities.

The Occupational therapist in the treatment of MHCU's

Occupational therapists play a key role in in-patient care of clients in acute mental health settings, where the four key areas of practice are: individual assessment, therapeutic groups, individual treatment and discharge planning[16].

Occupational therapists have expertise and skills which translate into a unique practice of group-work, specifically occupation-focused groups[14]. These groups differ from psychology groups in that they include activity or "occupation" such as art, music, movement, role play, sport, activities of daily living, games and leisure[13,17,18]. Occupational therapists use meaningful activity to provide authentic opportunities for clients to improve life skills and interpersonal relationships[14]. Group therapies within the discipline of psychology utilise a range of theoretical frameworks such as behavioural, cognitive, humanistic-existential and psychodynamic therapy, which may involve talk, interaction, reflection and interpretation[19].

The value of group therapy

Although there is limited research on occupational therapy group work, there is extensive literature on group therapy from the field of psychology. Group therapy has been shown to have many benefits to MHCUs[11–13,20,21] and is an effective form of therapy that is able to provide clients with as much benefit as individual therapy[11]. The fact that group therapy is both effective and efficient with therapists' time makes it a vital tool in mental health care.

Madeleine Duncan[13:266] summarises the value of group therapy when she says: “The group experience is primarily used in occupational therapy to help the client gain more appropriate intra- and interpersonal behaviours”. This study explores how the clients have benefited from group therapy in terms of both their intra- and interpersonal skills, and how learning from the group has been transferred into personal relationships.

Study Context

This study was set in an acute, voluntary, private in-patient psychiatric clinic in KwaZulu-Natal, South Africa, which admits clients with mental health challenges such as mood disorders, post-traumatic stress disorder and anxiety disorders. The treatment plan offers five groups per day, covering the themes of self-awareness, emotional management and interpersonal skills. In addition to occupational therapy and psychology group interventions, individual psychotherapy, as well as psychiatric consultations are offered. Although a three-week programme is offered, the average length of stay is 14 days.

Methodology

Design

A qualitative design was used to explore clients’ perceptions’ of group therapy, as this paradigm is concerned with meaning and lived experiences [22], and allows for rich, detailed, in depth study[23,24].

Participants, Sampling and Data collection

Clients from the clinic’s general unit formed the population for this study. Clients in this unit are admitted for the treatment of mental health disorders, which are not co-morbid with any substance abuse. Purposive sampling, a non-probability sampling technique, was used to access this sample; by only including clients who met the inclusion criteria into the sample.

This technique is most often used in clinical research to select the most appropriate clients to a study[25]. Clients participating in groups held within the higher functioning, general unit during the data collection period, were included in the sample if they had not displayed any psychotic features during this time and had signed informed consent to participate in the research.

The data was collected over four months, through a series of four 60-minute focus groups, one after each 'Interpersonal relationships' themed week. Focus groups are effective as they are non-threatening, and helpful in obtaining people's perceptions[26–28]. The population was invited to join the study, were clearly informed of the aims of the study, that their participation was entirely voluntary and their decision not to participate did not impact on their further treatment in any way. Twenty-five clients, five males and twenty females between the ages of 18 and 50 years of age participated in the study. In order to protect confidentiality and ensure anonymity, each participant was given a pseudonym. The focus groups were audio recorded and the facilitator followed a semi-structured interview schedule, which was consistently applied across the focus groups.

Findings and Discussion

Three main themes from the data will be presented. The first theme, **we all have relationship problems,** outlines the participants' understanding of their relationship problems. The second theme, **we were given the skills and applied them,** describes how group therapy helped them develop further insight and acquire greater relational skills. Then finally, **I am less demanding now**, describes how developing insight and skills have impacted on the participants' actual relationships and their hopes for their relationships.

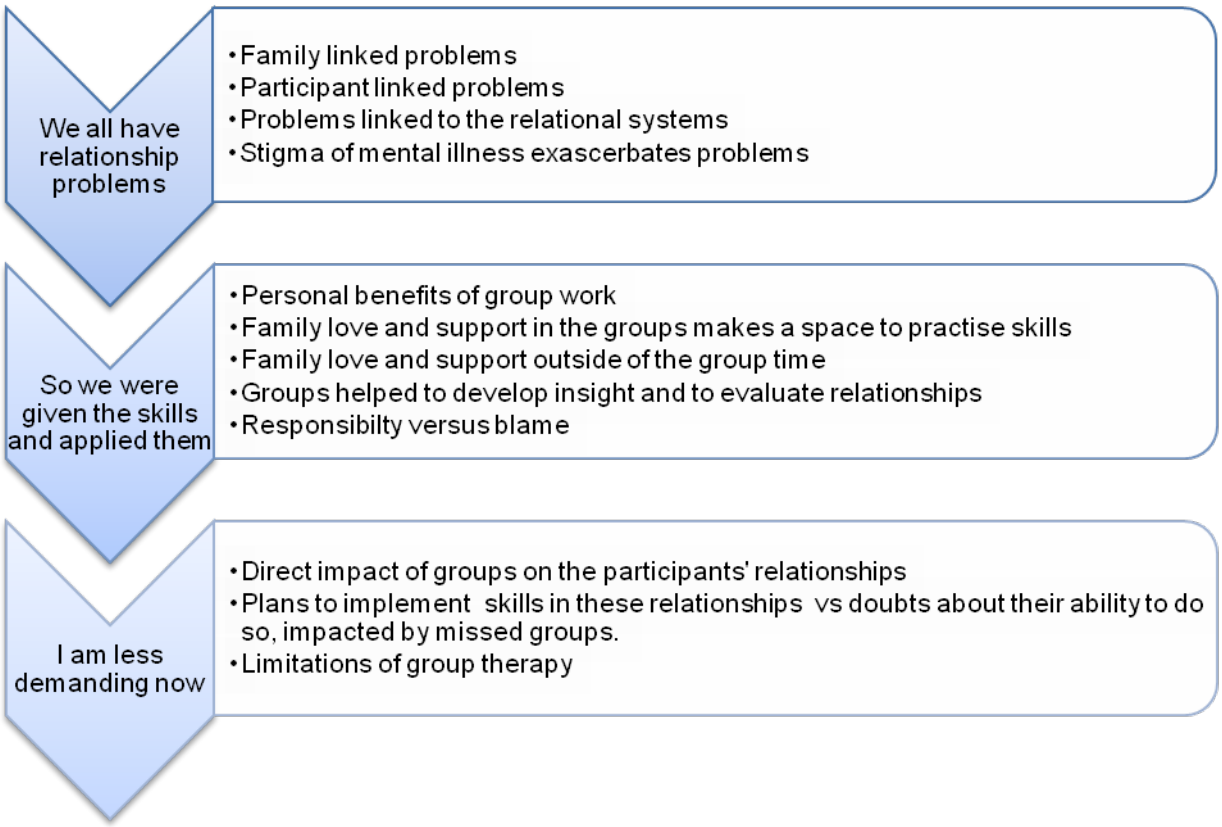

Figure 1. Summary of themes and sub-themes

Theme 1: We all have relationship problems

The participants shared that they all have relationship problems which stem from their families and from themselves; and that some problems were entrenched in the family system itself. They also expressed that their experience of stigma due to their mental health conditions contributed significantly to their relationship problems.

1.1 Problems linked to the participants' families or partners

Although participants reported that many of their families were financially supportive, they did not offer the emotional support that the participants desired. Three participants shared that their partners were not invested in the relationships, and that they either shut down communication or changed for a short time before reverting to previous behaviours. This led

to a sense of despondency and apathy in the relationships. This was illustrated by Sibongile who shared that there is often no good time to deal with conflict *"because you find that if you wait for tomorrow he will not be there*". Sné reported that she had expressed her feelings to her partner many times, but the change in him was short lived, leading to despondency: *"I thought no, the only thing that I have told him is that I am tired, I just shut up and just see, he has to do as he pleases, that's it".* Sné learnt that communicating her emotions with her husband was futile, and chose to keep silent. She further revealed that when her husband brought his girlfriend into their yard she was angry and hurt, but remained silent, and her thoughts turned to other ways of punishing him; this was when she decided to seek the help of her psychologist. Sné's account highlights how MHCU's endure maladaptive relationships which negatively impact their mental health.

1.2 Problems linked to the participants' themselves

The participants expressed responsibility for many of the problems in their relationships, including difficulty maintaining relationships, distancing behaviour patterns and poor emotional regulation. These problems correlated with difficulties experienced by other MHCUs including difficulty forming relationships, anger, and isolation[11,13]. Menzi shared that he has: *"been generally having difficulties maintaining relationships".* He further explained that it was only through his admission that he gained insight into the significance and cause of his behaviour.

The participants were aware that their distancing behaviour patterns and their poor emotional regulation were undermining their relationships. Thandiwe spoke about this: *"I'll keep quiet. I just not even tell you that I'm not fine. Isolate myself. I don't really have friends*". She spoke further about her demanding behaviour towards her partner*: "I will wake him up during midnight, call him once in...I hate it when he says: 'I'm sleeping'"*. Difficulties' with emotional

regulation were highlighted in: *"I would also be very emotional, and like Nandi, at night I…would even wake up and cry and I'd cry and cry and I'd cry…I would come from work and perhaps I wouldn't notice it but I would just shout, and then he'd tell me that you know immediately when you walked through the door you started shouting, … at times I'd be very angry, I'd be irritated" (Zodwa).*

The participants also cited difficulties understanding themselves and their diagnosis, therefore making it difficult to explain their feelings and behaviour to others. Peter said: "*[I] sometimes get into an argument with my wife I find it very difficult to think clearly and understand what I am feeling and why I am feeling it, and so it just gets left*". These descriptions display a negative impact on their lives linked to their mental health difficulties and their social skill challenges. Their maladaptive relationships exacerbated their mental health difficulties, creating a downward spiral.

1.3 Problems linked to the participants' relational systems

Disrespect and distrust in the family systems fuelled poor communication from silence and secrets to abuse and aggressive behaviour. Khanyi shared that her*: "husband kept this big secret that almost made us go through a divorce"*, while another participant found that the financial power imbalances in the system prevented family members from supporting her, they rather remained silent out of fear of losing the financial support of her partner. Participants reported verbal, mental and physical abuse that was captured in the following quote: *"the verbal abuse and the mental abuse I had with my ex-girlfriend".* Thandiwe reported she had a conflict with her partner over a phone call: "*And then we fought over that phone and then I ended up beating him".* The verbal and physical abuse, suspicion, and disrespect came from both the participants and their loved ones and appeared to be entrenched in the thinking and behaviour of the family in general. There seems to be a link

between mental health and living in a system with poor interpersonal styles; which is similar to a link between marital distress and depression that was noted in literature[29].

Communication and conflict management were topics discussed in all four focus groups. Participants shared about poor communication styles, indirect communication and faulty personal assumptions. Personal assumptions regarding family reactions are seen in the following quote: *"Even though I would like to speak to them I don't think they would listen" (Bandile).* Zodwa highlights the poor communication styles in her system, from both passive silences to aggressive screaming*: "He's the kind of person who just keeps quiet; you can scream, do anything. He will just look at you".* Participants also shared about punishment, threatening and abandoning behaviours in their family systems. Mpume mentioned her reaction when people do not immediately respond to her: *"like come to a conclusion like say: 'no you know what, you ignored me, I'm not going to answer your calls, umm you abandoned me and stuff'".* Through this quote, Mpume displayed how she had been demanding in her relationships and how she makes assumptions of abandonment when others do not respond immediately. She acts on this perceived abandonment with rejection and punishes others without communication or clarification.

Finally, participants mentioned that the discord in the family left them feeling hurt, rejected and isolated. These findings concur with the findings of Hammen and Brennan who speculate that: "these patterns result not only from maladaptive skills and schemas about the self and others, but also from the life contexts of the depressed women" [30:154]. Data revealed that MHCUs have poor social skills, and appear to come from family systems with inadequate social skills and maladaptive patterns of relating.

1.4 Stigma of mental illness exacerbates problems

Participants cited the stigma of having mental health problems as impacting on their relationships. Participants described both social stigma and internalised stigma, which related to feelings of shame and disempowerment. This resulted in participants attempting to hide their mental health difficulties from others, including their admission to the clinic.

Stigma directed at the participants left them feeling misunderstood, disempowered and rejected. Social stigma has been described in literature as occurring when large groups of people endorse stereotypes of a stigmatised group, and as a result act against this group [31]. Participants interpreted others' negative behaviours towards them as motivated by stigma. Gossip is an example of stigmatising behaviour experienced by the participants in this study. Buhle describes a conflict with her mother and sister who: *"were gossiping about me not talking to me, so what am I supposed to say? Just because you are crazy so you have no opinion at home".*

Social stigma was implicated in the development of silence surrounding mental health concerns of participants. Sné described how she felt uncomfortable telling others where she was: *"you can't share with someone else, yet you know your mentality some people took it differently, you see, if you are here, meaning that your mentality is not stable".* The social stigma experienced by this participant resulted in her being silent about issues pertaining to her mental health. She wished that the clinic's identity could be hidden or changed so that she *"can be accommodated without...having the stigma of being here".* Buhle went on to describe how people have responded to her: "*Anything and everything I say, 'oooh, don't worry she's crazy'*". The experience of these participants is consistent with literature which states that people living with mental illness can feel like they are devalued and discredited by society [31].

Internalised stigma "can be described as a process whereby affected individuals endorse stereotypes about mental illness, anticipate social rejection, consider stereotypes to be self-relevant, and believe they are devalued members of society"[31:2154.] The participants did not see themselves as insane, "I don't see mad people here" and yet they responded to their mental health issues stereotypically. Thandiwe reflected: "*Myself I had that stigma… I can never go and be admitted here in a psychiatric hospital… while I am a health worker".*

The impact of stigma on people with mental illness is well documented in literature [31], however, the large significance of stigma on participants' relationships was an unanticipated sub-theme of the data, and highlights the need to address this more directly within the group therapy programme.

Theme 2: "*So we were given skills and we applied them"*

Participants described significant benefits from group work, on both a personal and a relational level. This was primarily from developing greater insight into their difficulties in relationships and the resultant behavioural change after using the skills gained in the groups. On a personal level, participants reported improved self-esteem and creativity, as well as renewed motivation for participation in their careers with a more positive view of the future. They felt greater levels of personal power and choice while the group space gave them clarity of thought which assisted in problem-solving. A study by Adams and Casteleijn [32] supports this finding, they emphasise that mutual participation in an occupation can benefit individuals on a personal level, for example, through improved confidence levels.

2.1 Benefits of group work on a personal level

Participants found the support that they received in the group felt authentic and meaningful. Khanyi gave voice to this sentiment: "*They are not feeling pity for me and they are not faking*

it. They mean what they are doing and are really supporting". The participants asserted that is what gave them hope and helped reduce their symptoms quickly. Mpume echoed this sentiment: *"Group work actually had a huge effect on me and actually I felt supported, and then afterwards I went to see my psychiatrist, and well I was open with her shared most of my feeling with her and ja to my surprise that is why I am here, now I am feeling all healed and stuff".* These comments support literature that states the emotional support that clients receive in the initial stages of group therapy is the most important aspect of therapy [8]. A significant benefit of group therapy over individual therapy was that of "*universality"*, and *"instillation of hope",* as described by Yalom and Leszcz[11:1] Buhle: "*…I realise I am not alone. It gives me that hope".* Buhle experienced the power of universality and developed hope, helping her to feel better.

2.2 Family love and support inside groups makes space to practice skills

Participants shared extensively about their experiences of love and support within the groups, even referring to the group as a family. This finding is supported by Yalom and Leszcz who describe the therapy group as a recapitulation of the primary family group[11]. Buhle gives voice to this feeling: "*… this is your family, [only] better, from home*". Buhle compares the group to her biological family at home and finds the groups' support is better than what she receives at home. She goes on to say: *"it's not like with your psychologist…these people they'll tell you something they went through",* emphasising that participants found the authenticity of other group members sharing or offering advice from their own life experiences as beneficial. Mpume, despite being fairly new to the group said: *"I felt loved, support, hence I didn't know most of the people that well, I'm still new here. But it was so warm, I felt like it was my family I felt when I was taken care of".* Their descriptions of the group space were reflective of Yalom's therapeutic factors, particularly: "*universality and the corrective recapitulation of the primary family group, catharsis, and group cohesiveness*"[11:1].

Participants related an incident in which a participant became angry during a group and left. Later the group was able to discuss and resolve the conflict. In reflecting on this process Khanyi shared: *"But I must say guys, I am proud of the way in which we handled the conflict we had within the family…so we were given skills and we applied them".* The group is a useful place to learn skills, to apply them in the here and now with a multifaceted positive outcome, which included feelings of pride, the experience of success, improved group cohesion and conflict management skills.

2.3 Family love and support outside of group therapy time

Member subgrouping, and contact between group members outside of group time is discouraged by Yalom and Leszcz[11] as the problems of extra-group relationships are complex. In the South African context, support groups post-discharge are rare, and often difficult to access. Musa shared how much they valued the time spent with each other after groups: *"To work as a team, even outside, even outside there on the breaks we are talking to each other".* Buhle disclosed: *"we formed a WhatsApp group…, you know people there, they are still talking they are still saying their problems and we try to help each other"*. Mandla spoke of a supportive relationship he had developed and shared: *"we will keep in touch to check me up, if I am doing right, guiding me".* Although Yalom and Leszcz say this does complicate the group dynamics, they add that in some groups extra-group activities have been beneficial[11]. As described by the participants above, in the South African context there seem to be some benefits to this behaviour such as creating opportunities for those without transport or finance for further health care, to access social and emotional support and be reminded of skills learnt. Research into the long-term outcomes of this type of contact would be valuable.

2.4 Groups helped to develop insight and evaluate relationships

A significant theme, in the study, describes how groups helped clients to evaluate and develop insight into their relationships and their patterns of relating. Zodwa is a testament of this, pre-participation in occupational therapy groups she was unaware of her relational problems: *"I didn't realise that I was having problems per se, I just thought that I was being me".* Post occupational therapy intervention, she had gained insight into her problems with interpersonal relating and gained a deeper understanding of the mechanics and components of communication, including perspective taking, choosing the appropriate time and place for communication, emotional control and de-escalation of heightened emotional arousal. Zanele shared about the importance of learning about healthy and unhealthy relationships: *"…how is a healthy relationship supposed to be and most importantly communication styles...you might think that I am approaching you in a good manner but it's actually not a good manner and being assertive…could assist me like in rebuilding or reconstructing my relationships".* Grant shared that he had learnt about aspects of communication: *"I know now how to communicate properly. Cept, you know, not having that attitude or not having that certain body language that shows that I have got a attitude. I know which tone of voice to use"* (said with a closed body posture). Participants reflected that they had gained much knowledge in how to communicate more effectively and understood the mechanics of communication. However, Grant illustrated that it was a learning process and that knowing about communication and practicing the skills does not necessarily mean that participants will consistently be able to apply what they have learnt.

2.5 Responsibility verses blame

A significant change noted in the participants was a shift from blaming others for problems, to taking a greater level of responsibility for their own contributions to the relational difficulties.

This is reflected in Sarah's quote: "*I am sorry for the hurt that I have caused him, and I see now that most of the arguments that did happen was because of my tantrums…instead of blaming him; 'it you, it's you, it's you' I took blame this time".* Sarah gained insight, through groups, into her contribution to their relational difficulties and gained a more balanced view of the relationship.

Theme 3: I am less demanding now

In all four focus groups, participants reported finding improvements in their relationships. They discussed changes already noted in their relationships, plans to implement some of the skills learnt and how this is giving them hope and finally the limitations of group therapy in terms of repairing relationships.

3.1 Direct impact of groups on the participants' relationships

Participants felt that they were less demanding, more trusting and able to recognise the needs of others more easily. Londi shared*: "I've learnt trust, to trust people that are around me".* They reflected that they had stopped isolating themselves and were socialising more with the other group members as well as their families, as reflected in Bandile's quote: "*The change I've noticed, now I can sit with my family around the table have a nice chat, and with my friends".* Janet used assertive communication skills with her mother: *"she was very understanding…it has brought my mom and I a little bit closer together then before".* Bandile reinforced this when he said: *"I am speaking out and telling them how I feel. Now I can see their response…changing is giving me that comfort that I needed before".* Both Janet and Bandile demonstrated that as they started changing the way they communicated in their relationships, their families' response and the actual relationship itself improved.

Group therapy assisted participants to establish boundaries in their relationships. Wandile, initially *"not a confronting person",* went on to describe how she had been able to confront her cheating partner and tell him that she was ending the relationship. Khanyi summarised these changes: *"I just found a calmer way of talking to him. Like I feel, like he may be pleased with this type, I am less demanding now. I'm less pausitive* (possessive) *now, I do recognise his needs now. I used to put my needs before his. I learned that he make mistakes and I think there is still hope for us now".*

3.2 Plans to implement skills in these relationships verses doubts about their ability to do so, impacted by missed groups

The above factors contributed to the hope for their relationships in the future and for prospective adaptive relationships. Participants planned to bring a healthier self to these relationships, to improve their communication with others, and to apply the skills they had learnt. It was significant to note the impact of missed groups on the participants' ability to feel confident in applying their skills. Fikile attended a group on assertiveness, which Buhle had missed. During the focus group Fikile spoke about her desire to be assertive at work: *"That I am allowed to have problems, and I have got leave and I am allowed leave, so please stop talking behind my back, if you have a problem with me please address it".* Buhle, who had the same work context as Fikile, stated somewhat wistfully: *"I wish to do that, but it seems impossible at my work".*

Even though group therapy gave hope to most participants for their future relationships, some held doubts and insecurities about applying these skills. One participant wondered if the theory would be effective in practice. Participants expressed doubt that they would not know what to do if people responded badly to their attempts to communicate. Even though the participants had been given assertiveness training, some participants had difficulty

transferring these skills as they were unable to be assertive with the exercise instructor, demonstrated when Buhle reported: *"they are afraid to ask him to lower the tone".*

3.3 Limitations of group therapy

The participants were aware that one of the limitations of group therapy is that it cannot change the outside world, and some of them faced the challenge of returning to maladaptive or abusive relationships. Systemic problems are not solved by treating the individual, however. Fikile speaks to this problem when she describes the power of choice that victims of abuse have: *"yes, you have a choice, you can say: 'I didn't have a choice… I stayed until you beat me up and I lost my leg'. No, you had a choice you have to accept that I am being beaten up or exit".* Although group therapy does not treat the whole family system, some participants left feeling empowered to change the system, and others found as they changed their behaviour, the system also changed.

Conclusions

Participants described the significant problems they experienced in interpersonal relationships, with many of the participants enduring long-term maladaptive relationships. A downward spiral seemed to develop through the interplay between mental health disorder symptoms, such as poor emotional regulation, and deteriorating relationships. The stigma of being diagnosed with a mental health disorder appeared to aggravate this spiral.

During group therapy, this downward cycle appeared to start to reverse, as the participant received acceptance, authentic support, and social connection. This provided a safe space to practice social skills and as a result strengthen self-esteem and positive relationships, leading to a greater level of acceptance and mental health. As the group members improved and practiced their skills within the supportive environment of the group, they gained the confidence to apply skills in their personal relationships, setting firmer boundaries in some

relationships and deepening connections within others. Although group therapy does not directly change unhealthy systems, the group member was left empowered to accept the system, change their part of the system, or leave the system. Although the participants described changes, growth and empowerment, they were also aware that they had started a journey which could not be completed during an acute admission. Buhle gives voice to this: *"for me, I can say it's a long, long, long road to walk; I still need to walk, because I only just discovered myself".*

Recommendations

As difficulties in relationships are so pervasive among MHCUs, Buhle made the following recommendation: *"I think it would be more beneficial to others if at least once a week there was a day put down on schedule for that* (relationships groups) *because some of the people, they are here for like five days".*

Although participants have learnt the theory of communication and had some opportunity to practice, they were not all able to apply all skills. Continued opportunities to practice and apply skills need to be regularly offered in the group programme. Missed groups were seen to have a significant impact on the participants' skills, even though it was inevitable due to individual consultations with doctors and psychologists, physical illness and the need for further testing or scans. Improved communication within the multi-disciplinary team and better scheduling of the programme may assist in reducing the number of groups being missed.

Greater levels of support are necessary for the participants after discharge, to assist them with coaching and support as they implement the skills that they have been taught in therapy. Many of the clients live far away from the clinic and rely on public transport for access. A post

discharge group was offered, however, this required financial commitment from clients, and made it inaccessible for those without adequate financial resources. Consequently, this support group has recently been offered as a free provision to improve uptake of this service. It is recommended that this service be promoted and additional barriers to attendance be identified.

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2.7 BRIDGING

As an occupational therapist working in this environment, I hear the story told by article one, developing daily, and experience the power and value of occupational therapy group work in the lives of individuals. In article one, even though group work is the vehicle of change, the focus is on the change in the participants and their relationships. As discussed in the literature review of this article, this journey has not been thoroughly described in literature. This limits our ability to learn from each other as therapists working in this field and decreases our perceived value from other professionals working within our teams. This article is an attempt to start to tell this story so that as therapists we can learn from how the clients see occupational therapists and our groups and thus be able to provide therapy in a more client-centric way.

Rather than telling the clients' stories of relationships, the second article answers the question of how clients value and feel about the groups that occupational therapists use. The focus in this second article is on the vehicle of change, group work, and less on the change noted in the relationships themselves. After a review of literature, only one study could be found describing occupational therapy groups in an inpatient setting, this was a small pilot study conducted in 2005 (Cowls *et al.*, 2005). As a therapist working in an acute unit, I would like to make the most effective evidence-based decisions to ensure that clients are able to receive the best quality care that we can provide, without research in this area this is difficult. This article is an attempt to start building up the information we have available so that we are able to make more effective, evidence-based decisions in our practice of group work. This article, although discussing occupational therapy groups, has relevance to all practitioners involved in group work.

2.8 PUBLICATION DETAILS: ARTICLE 2

Title: "The insider perspective: Occupational group therapy process and content in an acute mental health facility."

Author: Andrea Radnitz

Main supervisor: Chantal Christopher

Co-supervisor: Thavanesi Gurayah

Status: Submitted to the journal

2.9 JOURNAL INFORMATION

This scientific journal article was written for publication in Groupwork. This is a British based journal, which publishes journal articles with relevant social applications of group work, this includes occupational therapy and mental health, making the article very relevant to their scope. References for this journal must adhere to an adapted Harvard referencing system, as described on their website and in Appendix J. The document lay-out is in accordance to the journals guidelines to the author.

2.10 ABSTRACT

Background: Set in an acute inpatient psychiatric clinic, this study investigates clients' perspectives of occupational therapy groups, in terms of group content, process, and techniques.

Purpose: This qualitative study was designed to explore occupational therapy groups to inform effective technique and content choices.

Method: The participants' experiences of groups were studied through the use of four, sixty-minute focus groups which were audio-recorded and transcribed. Thematic analysis was used to analyse the data. Findings: Four themes from the data are discussed in this article namely: group description, techniques, content, and process.

Conclusions: The findings of this study suggest the therapist's style and rapport is of significance to the clients, who generally preferred smaller, more intimate groups and a flexible, interactive therapist who was able to control the group and could use humour and self-disclosure appropriately. The importance of group member participation, purposeful activities, and real-life examples helped to reduce symptoms and assisted with concentration and skill acquisition. Group content on relationships is of importance, however, in the acute phase of treatment therapists need to keep this simple rather than include too much information. Group therapy is complementary to individual therapy, and both of these modalities are important in the treatment of clients in this phase of recovery.

2.11 ARTICLE 2

The insider perspective: Occupational group therapy process and content in an acute mental health facility.

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Keywords: mental health, occupational therapy, group work, inpatient, techniques

Abstract:

Background: Set in an acute inpatient psychiatric clinic, this study investigates clients' perspectives of occupational therapy groups, regarding group content, process and techniques. Purpose: This qualitative study was designed to explore occupational therapy groups to inform effective technique and content choices. Method: The participants' experiences of groups were studied through the use of four, sixty-minute focus groups which were audio-recorded and transcribed. Thematic analysis was used to analyse the data. Findings: Four significant themes from the data are discussed in this article namely: group description, techniques, content and process. Conclusions: The findings of this study suggest the therapist's style and rapport is of significance to the clients, who generally preferred smaller, more intimate groups and a flexible, interactive therapist who was able to control the group and could use humour and self-disclosure appropriately. The importance of group member participation, purposeful activities, and real-life examples helped to reduce symptoms

and assisted with concentration and skill acquisition. Group content on relationships is of significant importance, however, in the acute phase of treatment therapists need to keep this simple rather than include too much information. Group therapy is complementary to individual therapy, and both of these modalities are important in the treatment of clients in this phase of recovery.

Introduction:

Therapeutic groups are a mainstay of treatment in psychiatric occupational therapy practice. Group therapy is as effective as individual therapy and is cost effective and resource economical with therapists' time (Yalom, and Leszcz, 2005; Lorentzen, and Ruud, 2014) and has shown many benefits to clients with mental illness (Yalom, 1983; Finlay, 1993; Duncan, 2014; Corey, Corey, and Corey, 2008). Although group therapy is a vital tool in the treatment of mental health care users (MHCU), there is limited research on this tool from an occupational therapy perspective (Cowls, and Hale, 2005). This article explores the group content and process of occupational therapy groups in a private, acute mental health setting in South Africa, through the eyes of the group members themselves, in order to understand current services and influence future interventions offered to clients with mental health difficulties.

The philosophy of occupational therapy is that purposeful activity, or occupation, may be used to mediate dysfunction as participation in occupation has both intrinsic and therapeutic value (Trombly, 1995). Based on these foundations, occupational therapists have a unique practice of group-work, specifically using their skills and expertise to facilitate occupation-focused groups (Occupational Therapy Association of South Africa, 2014). These groups include purposeful activity such as art, music, movement, role play, sport, activities of daily living, games and leisure (Duncan and Prowse, 2014; Nott, 2014; van Greunen, 1997) within the group format. Occupational therapy groups differ from psychology groups in that psychologists utilise a variety of theoretical frameworks such as cognitive, behavioural and psychodynamic therapy, that usually facilitate healing through discussion, reflection and interpretation (Pomerantz, 2017).

One of the overarching goals of occupational therapy, according to the occupational functioning model is improving clients' competencies in their self-identified important life-roles

resulting in an improved sense of efficacy and self-esteem (Trombly, 2014). Occupational therapists use a range of therapy groups, each with its own aim and purpose these are classified into four types, task, social skills training, communication and psychosocial groups (Finlay, 1993). Communication and psychosocial groups overlap with other professionals, while task groups and social skills training are more specific to the scope of occupational therapy practice. The study site used all of these group types to develop social competence and improve interpersonal relationships in clients who have difficulties in this area.

A similar study was conducted in Canada by Cowls and Hale (2005), on what clients' value in OT groups. They found that for the clients, it is activity that really counts, as not only did the clients prefer activity-based groups to verbal groups, but they also demonstrated a greater improvement in skills after attending activity-based groups. Their clients' valued topic related warm-ups and activities, and repetition of information as retention is negatively impacted by anxiety. Their clients had a mixed response to skills teaching, with all but one client finding it valuable. Clients valued group cohesion and support from other group members both inside and outside of the groups and found hearing others' experiences beneficial. Several clients appreciated anger management and assertiveness training and wanted more of this in the programme, however, others found it overwhelming (Cowls and Hale, 2005).

Study Context:

This study set in KwaZulu-Natal, South Africa, was conducted at a private in-patient psychiatric hospital, admitting voluntary clients in the acute phase of treatment for an average stay of 14 days. The three-week therapeutic programme included individual psychotherapy and psychiatry, as well as occupational therapy and psychology group interventions, covering the themes of self-awareness, emotional management, and interpersonal skills. The clinic contains two units, a general psychiatric unit and an addiction unit.

Methodology:

Design:

Qualitative research adds a human element to scientific research, and allows health scientists to explore the reasons why interventions succeed or fail (Terre Blanche, Kelly and Durrheim, 2006; Starks and Brown Trinidad, 2007), therefore it was well suited to this study as it enabled the exploration of the value of specific techniques of group therapy.

Participants, Sampling and Data collection:

Clients from the general unit formed the population for this study. These clients were admitted for the treatment of mental health disorders, such as anxiety disorders, mood disorders, and post-traumatic stress disorder, which are not co-morbid with substance abuse. Purposive sampling was used and is often used in clinical research where patients who meet the inclusion criteria are chosen as a part of the sample (Acharya, Prakash, Saxena and Nigam, 2013). Clients were included in the sample if they had been admitted to the higher functioning general unit group during the week of the data collection, had no active psychosis for at least seven days prior to the focus group, and had given informed consent to participate in the study.

The data was collected during four 60-minute focus groups, over a four-month period, each one after the interpersonal relationships themed week. Focus groups produce a rich data set in the participants own words, allowing them to qualify their answers and limiting artificial responses (Stewart and Shamdasani, 1998).

The population was invited to join the study, they were clearly informed of its aims and that their participation was voluntary, and that their decision not to participate did not impact on their further treatment. Twenty-five clients between 18 and 50 years of age participated in the study; of which twenty were females and five were males. To ensure anonymity and protect confidentiality, each client was given a pseudonym. The focus groups were audio recorded. The focus group facilitator followed a semi-structured interview schedule, which was consistently applied across the focus groups.

Findings and discussion:

Four significant themes from the data are discussed in this article. The first theme is a description of the groups in terms of the therapist's profession and style, the group size, duration and physical structure. Clients also had thoughts on the structure of the timetable. The other three significant themes were group techniques, group content and group process.

Super-Theme	Theme	Sub-theme	Micro-theme
Occupational Therapy groups	Group Description	Group size	
		Group therapist	
		Open groups	
		Time frame	
	Group Techniques	General group techniques	Group handling skills
			Warm-ups
			Examples and demonstrations
			Participation and interaction
		Specific group techniques	Craft groups
			Relaxation, reflection and role-play
	Group Content		
	Group Process	Group cohesion and norms	
		Individual therapy verses group therapy	

Figure 1. A Diagram illustrating the themes and sub-themes

1. Group description:

Clients discussed their preference of group size and the therapist's style. They observed the value of having open groups and discussed the group time frames.

1.1 Group size:

Clients are placed in smaller groups, to promote open discussions. Due to staffing shortages two of the smaller groups are sometimes combined. This is usually for sessions such as psychoeducation or relaxation where the group size is less significant. This rationale is congruent with literature on the topic that psychoeducation groups, relying on didactic

information may be effective with as many as twenty to thirty participants (Yalom and Leszcz, 2005).

All but two of the participants expressed that they strongly preferred the smaller groups (6-12 clients), supporting Yalom and Leszcz's (2005, p. 293) contention: 'in inpatient settings, groups of five to eight offer the greatest opportunity for total client participation'. Particular likes and dislikes of small and big groups can be seen in the following quotes: *'With the small groups it's very intimate; it's very powerful…although the bigger groups helped me also…at times perhaps you'd end up losing a bit of concentration*' (Zodwa). Other positives regarding small groups are: *'more work gets done'* (Sarah), and '*the OTs can control a smaller group easier, sometimes it can get a bit, not out of hand, but sometimes someone makes a funny remark and then someone else makes a funny remark and then to get it under control again just takes a bit of time*' (Peter). One of the significant negatives of larger groups was that many people were more inhibited in them, while less inhibited members use the group time. The group strongly agreed with Sné's comment: '*We end up hearing one and the same person...yet the group is big'*. Janet's comment reinforced this: '*having a smaller group it makes me feel more comfortable to open up'*. This effect of the bigger group being dominated by more forceful members is described in the literature (Yalom and Leszcz, 2005).

Factors that made larger groups intimidating were a fear of the unknown or of judgment. Khanyi commented that she was afraid when she was first in a combined group: *'Honestly guys I was terrified. But then when I got here I'm like it's the same faces I know it's the same faces I laugh with, what is different? Then it was just okay, just like that'.* Fear is described in literature as one of the factors that people experience in pre-group preparation (Yalom and Leszcz, 2005). This fear is what held Khanyi back from the larger groups. Once present however, she became more comfortable and benefitted from the group, reinforcing Yalom's statement that larger groups can be effective. Grant singularly expressed a preference for bigger groups: *'I enjoy it when we combine the groups, coz then we have got more, I think we have more fun'.*

Bandile summarised the participants' thoughts on the group size: *'Ja, the smaller groups is very better'.* Data revealed that although there is benefit from larger groups, the majority of participants preferred smaller groups as they were able to concentrate more effectively and felt more comfortable sharing.

1.2 Group therapist:

A focus group question discussed the role of occupational therapy and the role psychology groups within the programme. Clients did not comment on the roles of different therapists, but rather focused on individual therapists attributes. Seven of the clients reported that they had not noticed any difference while five clients reported that they had noted a difference. Differentiation in the group was linked to the therapist's personal style and skills, and not their profession. Julie: *'the psychologists allowed you to talk more, whereas the occupational therapists used to… they used to facilitate and talk more themselves'.* In contrast, Musa shared: *'Ja, the psychologists they don't give us enough time to talk, about our problems, they are just teaching'.* Mandla offered a difference of opinion: '*the OT's to me they are more people-centred you know, focused to the patients, and psychologists are more focused to the subject'*. These quotes suggest that clients did not value one profession over the other; in fact, seven of them did not notice any difference in the therapists' profession. Instead of the therapists' profession being of significance to the clients, in all four of the focus groups, the therapist's style, values, and skills, along with the rapport they built with the clients were of greater importance. The clients' emphasis of rapport is congruent with literature, which shows that the development and maintenance of rapport with clients is linked to positive client outcomes (Leach, 2005), which Zodwa illustrates: *'I trusted the …OT. Ja, I entrusted her and, and the whole group with, with me'.*

Clients described some of the therapist attributes that assisted them in building this rapport. *Zodwa described an OT:* '*She is very …flexible … and when she talks she makes you feel comfortable enough to actually talk…'* Janet shared about how appropriate therapist self-disclosure was motivating for her, *'especially when the occupational therapist would give an example of her own… it would really make, stand out for me'.* Clients liked therapists that were funny, interactive and able to control the group discussion well. Wandile verbalised that on one morning they had had the same therapist for 3 groups, *'it was too much'*, illustrating that changes in facilitators helped sustain clients' levels of concentration.

1.3 Open groups:

In this setting, the groups are open, with new members joining and leaving the groups almost daily. Benefits of this are conveyed in the following quotes: *'each and every day a new person is coming with another story; you are experiencing another story, another story so each and every day you are learning new things' (Musa). 'When newcomers come in as well*

we try and' (Khanyi interjects: 'to accommodate them') 'ja, to accommodate them and make them feel comfortable' (Grant). In open groups, new group members are able to be supported by settled group members who are able to provide authentic encouragement. This accommodation of new group members allows for the practice of altruism and imitative behaviour, therapeutic factors described by Yalom and Leszcz (2005) which helps clients to be of benefit to others, thus improving their own feelings of self-worth, and to demonstrate or imitate appropriate social behaviours learnt from previous group members.

1.4 Time frame:

Three clients agreed that they would prefer shorter groups. Julie commented: *'I thought maybe forty-five minutes coz my concentration span isn't massively big'.* This is a valuable suggestion, however, OT's in South Africa are bound by billing codes which do not allow for shorter groups, to be ethically charged for.

2. Group techniques:

Clients commented on both the general techniques used in groups and specific techniques used in particular groups.

2.1 General group techniques:

General techniques included clients benefitting from the group handling principles, warm-ups, the use of demonstrations and examples, and particularly from participation and interaction.

2.1.1 Group handling principles:

The members of one focus group commented particularly on the group handling principles that they enjoyed. Khanyi reflected that she liked the fact that no one is forced to share: *'…they don't rush you. They tell you take your time...when you are ready you can talk'.* This helped her to develop trust and confidence in the therapist and group. Another client spoke of changes in group occupation transitioning between fun and serious, *'Just to twist things around'*. Three clients valued the inclusion of fun activities into the group seen in Anne's pleasure: *'everybody is laughing'.* Task completion, in both crafts and warm-ups, were pointed out as significant. Thandiwe described her excitement in the craft room: *'And you can't wait to finish what you are trying to do; you can't wait to see this creativity that you are doing'.* Khanyi expressed her sense of pride in their success when she said: *'And we got it right'.* This reinforced the importance of task completion and achieving success with MHCUs.

2.1.2 Warm-ups:

Two warm-ups were described during a focus group. The group expressed that these helped to: *'distract our minds'* and to *'like break the ice'*. Khanyi described how warm-ups helped to emotionally regulate the clients following deep or evocative groups: *'…because the process groups are good, but they leave us emotional, then after that if you come to class like that…ja, and then everybody is so upset' (Khanyi).* This focus group noted they would like warm-ups more often which concurs with Cowls and Hale's (2005) study that found participants valued warm-up activities.

2.1.3 Examples and demonstrations:

The technique of giving examples and demonstrations was beneficial across groups, *'it really helped to remember the point that was being made'* (Peter). Five clients described how the real-life examples of clients and therapists helped them, through resonance and motivation, *'there's an example of whatever it is that they are saying and most people can… relate to that' (Zodwa). 'I would see … it does actually work' (Janet).* Others suggested the use of technology to play video clip examples, *'that thing of projectors is helping because I have been in the trainings like first aid training…they are using these projectors for the videos just to show examples demonstrations dramatically' (Musa).*

2.1.4 Participation and interaction:

The importance of participation and interaction were common topics in the focus groups. Only Peter expressed that he preferred lecture style groups to more interactive or activity based groups: *'because I like to get content quicker, I like to know this is what we should or shouldn't do, and so on, but then afterwards then to have some sort of practical application of it is useful'.*

Sné pointed out that she struggles to concentrate in lecture style groups: *'I listen to a person standing in front of us, I just listen and listen and, and there is a time when I switch off my mind'.* The group agreed that they preferred lecture style groups in which they were expected to participate and interact with the information. Khanyi stated that it was easier to absorb information when they *'ask questions, give ideas, give thoughts'.* Cowls and Hale discuss how therapists tend to overvalue talking based psychoeducation groups yet their research found that by 'participating in interactive or creative activities clients' learning potential is maximised and powerful memories are made' (Cowls and Hale, 2005, p. 179). This found

support with the majority of the clients in this study, groups which included activity participation assisted clients with concentration and engagement which improved retention, especially with an acutely ill population.

2.2 Specific techniques:

The clients commented on the specific techniques used during the programme, particularly craft, role play, relaxation, and reflective groups.

2.2.1 Clients' perceptions on craft groups

The clients experienced mixed feelings towards the craft groups, although many clients found them useful, they also elicited some anxiety. Both the clients that saw themselves as creative and those that believed they were not creative enjoyed the craft groups and found them relaxing, meaningful and fun. Ayanda commented: '*the craft which is something I'm not used to, I actually loved it also'.* The clients found it helped them to concentrate and suggested that it be held daily. Two clients disliked craft groups, and Menzi described why: *'coz you have that pressure of creating whatever so the minute you walk in there, I panic because now that meant something has to be drawn or something had to be done, something creative'*. Craft groups with significance to the clients' relationships or group content were valued. They appreciated crafts such as card making which helped process and express their feelings. Nandi described a profound experience through making a card for her deceased father: *'I never got to know my Dad, and forever was...angry at him…when I came here they taught me almost everything to calm myself to accept and then…when they said we must do those cards, I think I should make him a card, telling him what I felt about him, and then in a way it made me realise how much I love him…and I had to make peace with him…'*

Crafts activities with less significance to the clients' process were less valuable. Sarah compared two of the craft groups: *'…when I went to my room I read what I had written and it really help me and really made me think, so what I did in that craft room really impacted on me but in that way it was helping us in not like the stress ball, you know we need something that will help us emotionally, teach us skills'.* Sarah found the craft group in which she was reflecting on her relationship much more meaningful than a craft group in which the group made stress balls for a charity. The stress balls group had no significance to the theme of the week, the aims were more about participating in community activity and encouraging creativity. This quote reinforces that occupational therapy task-based groups are not about

keeping the client busy, but about being absorbed in meaningful activity that produced a change in the client, and these groups are more valued by clients if the meaning or value is carefully and overtly linked to their therapy goals.

Two reflective groups using creativity to allow the client to reflect on life roles, and goals in relationships were included in the programme. Peter reflected on one of them: *'we had to identify different roles that we play, different types of relationships that we had and things that we can do to improve those relationships, I found that really useful'.* Two other clients agreed with Peter, speaking about how this helped them see their value and clear solutions. Using creativity for reflection was perceived as very useful.

2.2.2 Clients' perceptions on relaxation therapy, reflection and role play

Two clients mentioned that relaxation therapy was helpful, particularly for establishing a sleep routine. Groups that afforded clients opportunities to contemplate their feelings and thoughts during reflective exercises were useful in developing self-respect and in clarifying their feelings. Khanyi described her experience of one such group: *'writing letters to yourself, I found it very useful. So I wrote the letter to myself and now I am also much more used to using words like: I feel…'* The activity of writing was useful in practicing skills learnt in communication groups; she now felt more comfortable using these words and so was more likely to transfer these skills to her relationships.

All but one of the clients found role-play helpful, despite some clients finding it anxiety provoking. Sarah explained her thoughts on this: *'you'll speak like how you normally speak and they will correct you and tell you: 'you can handle it in this manner', and you will think to yourself: 'yes I can do that, my way is the wrong way I can be more humble when I am approaching a person''*. Zodwa found the experience of verbalising her feelings cathartic*: 'with the role play it was like now you finally get chance to say whatever you want to say to this person, imagine that this is this person what do you what to say'.* Thandiwe, although not actively participating in the role play, found watching and hearing the feedback valuable: *'when I heard people talking and then I was 'okay', this is what a person must do, this is how you are supposed to be handling A and B'.* Clients found role-play beneficial for the assimilation of new content as a practice round for real conflicts that they were going to be facing. On a deeper level, they found it cathartic to be able to express the feelings that they had been suppressing. This experience of role play is supported by literature which states

that role play helps participants to integrate content, emotion, and experience in a rich learning environment (Hubbard, 2014).

Clients found craft, relaxation, reflection and role-play very useful, in spite of some of these techniques increasing anxiety levels in some of the clients.

3. Group content:

Sné summarised her thoughts on the content of the programme: '*all the sessions, and what I can say about this week's session, oo, I enjoyed them a lot, felt like they were just talking to me also, coz some of the aspects they gave me the clear picture and the clear direction and the solution to my problems'.* This sentiment was echoed throughout the focus groups. Clients commented specifically on the adaptive and maladaptive relationships groups, the communication and conflict management groups and also the process groups.

Fikile described how much she valued the adaptive and maladaptive relationships groups, she: *'got to learn that there are two types of relationships, unhealthy and the healthy relationships and I learnt how to deal with the unhealthy relationships. And how to deal with the healthy relationships, it's been, it's really been helpful'.* Eleven clients agreed with Fikile that the group on abusive relationships was really helpful. Nandi added that: '*You have to set boundaries'* although this was not a group from the relationships week, she was able to link the content to her unhealthy relationships.

Communication and conflict are topics that were discussed extensively in the programme, all clients said they benefitted from these groups. Anne reported: *'I have learnt to not be so aggressive when I talk, I've learnt to not like judgementalise or not to overreact about something'.* In a different focus group Peter concurred: *'resolving conflict because I would just hide away from any issues I wouldn't discuss it, so finding positive ways in which we can resolve issues'.* Clients consistently agreed with Anne and Peter sharing how they had gained insight into their communication styles, and how this positively impacted their relationships.

There are some less structured groups during the day, which sometimes start with a warm-up, and include discussions of group norms, further discussions of skills or topics discussed in other groups, mindfulness of current emotions and general check-in and support. These

groups are run by a combination of occupational therapists and psychologists, in what Finlay (1993) describes as support or psychotherapeutic groups. At this clinic, they are referred to generically as 'process groups'. Nine clients expressed how highly they valued these groups. Zanele: '*very useful…they were…intimate…you really get in touch with yourself…'* Janet described why she values these groups*: 'because it's after one of the combined groups where they give us information, we talk about it in the process group, and help us to understand it and … live it'.* Ayanda mentioned that: '*Even when there was conflict, but there being someone to like control wherever a person goes with their mouth that in part helped a lot. And also the sharing of stories from the people and the learning...*' Ayanda's thoughts on these groups are reflective of the therapeutic factor of altruism as described by Yalom and Leszcz (2005), group therapy offers clients who initially feel useless an opportunity to offer something of value to others, that is support and learning from each other. Ayanda's comment on control concurs with Cowls and Hale (2005) who found that clients valued hearing others experiences when there are limits to the intensity and amount of disclosure.

4. Group process:

The last theme was on group process. Clients commented on the development of trust and openness in the group, the importance of group norms and also compared the process of individual therapy to that of group therapy.

4.1 Group cohesion and norms

Mandla described the development of the group: *'it starts tense, you are not free to express, but at soon as one person starts then it opens up'.* Thandiwe shared that she was one of the people who was able to open up: *'I just didn't care, I just have to talk, because I don't have the time to trust anyone, it was my first day and I had my problems and I knew this was the place for me to get help*'. She knew why she was in the group and was prepared to take risks to get the help that she needed, this shows some stress to get help and use limited therapy time well. Sné agreed with Thandiwe*: 'if you stick to trust you won't get help'.* Other clients took longer to share and needed to first develop trust in the group, Londi was one of these: '*I have learnt to trust people that are around me'.* There is a balance between risk taking to achieve one's therapy goals and developing levels of trust in the group, to feel safe. Respect for both those that took risks and those that need to first feel safe is important in the development of group cohesion.

The implementation of clear group norms was a significant contributor to the development of cohesion and trust. These norms were pointed out by a number of clients. Sarah highlighted: *'…there is no one judging one another'.* Zanele shared*: 'nobody's problem is more important than anybody else's'.* Sné highlighted the importance of support and confidentiality: *'just understanding each and every individual's difficulty...So it was like anything that you cough it out and also it sticks here'.* Buhle used the phrase 'it sticks here' to describe how when she shared her story, her confidentiality was respected, the story 'sticks' within the group. Noma mentioned that although she found both group and individual therapy beneficial, she preferred individual therapy: *'because of...Doctor-patient confidentiality.'* Clear group norms helped participants to trust and relate to each other in a safe environment and from their comments norms were of great significance to the participants, but were not always enough to help them share easily in the group. This data supports literature that describes group norms as creating a safe place for clients to be themselves and shows that compliance with group norms is an indicator for group cohesion (Sánchez Morales, Eiroa-Orosa, Valls Llagostera, Gonázlez Pérez, and Alberich, 2016).

4.2 Group therapy verses individual therapy:

In this setting, clients received a combination of group therapy, individual therapy, and psychiatry. Ten clients thought that groups and individual therapy were both useful. They described how these different modes of therapy worked together as the benefits of each were complementary; group therapy was authentic but could be more intimidating. Julie stated: *'they go hand in hand'.* Clients found it easier initially to open up to their individual therapists and found that they had more time to talk in their individual sessions. Wandile said: *'I talk exactly the personal things that I cannot share in the group'*. Khanyi shared how her individual therapist had helped her to open up in the groups: *'She is the one who gave me the confidence, that no these people will never harm you, some of them are going through the same things'.* Both individual and group therapy are important and complement each other, and the outcome seems to be improved when these therapists work together.

Conclusions:

This qualitative study investigated clients' perceptions of occupational therapy group interventions in an acute psychiatric context. Descriptions of client's experiences of groups may provide therapists with valuable insights regarding the effectiveness of these interventions.

The findings of this study suggest that facilitation of client-centred groups, which are participatory in nature, is vital to effective therapeutic interventions. A participatory focus enables clients to utilise and internalise skills offered during sessions. Through this process, these skills become part of client's 'skill' repertoire which they may draw from in their daily lives.

It is noteworthy that occupational group therapy is offered within an multi-disciplinary team approach, so clients were receiving individual psychotherapy and medication at the time of the study, the improvements noted in the clients are then not only impacted by group interventions but by team interventions. The clients' views are, however, valuable in describing the impact of specific techniques and intervention. It is significant to note that the findings of this study are very similar to the findings described by Cowls and Hale (2005) described in the literature review above. Despite differing backgrounds, cultures and therapy programmes the clients' thoughts on acute occupational therapy groups are generally consistent. This may suggest that a client-centred, participatory approach is commonly accepted by MHCU's.

Within this study, the therapist's style and rapport is of great importance to the clients, who generally preferred smaller, more intimate groups. They preferred a flexible interactive therapist, who was able to control the group and could use humour and self-disclosure appropriately. The importance of group member participation, purposeful activities, and real examples helped to reduce symptoms and assisted with concentration and skill acquisition. Although purposeful activities are helpful, therapists should be aware that they can also raise clients' anxiety levels.

While group content on relationships is of significant importance therapists need simplify rather than overload clients in the acute phase of treatment with information which they may have difficulty processing. In the acute stage of treatment, occupational group therapy is an important aspect of psychiatric intervention that appears to be especially effective when coupled with individual therapy. Therefore, therapists need to work together to ensure the best outcome for the client.

Recommendations:

Clients made three proposals for developing the group content. Firstly, they suggested introducing groups on stigma, as this was a significant factor in their conflict at home. The second suggestion was the inclusion of groups on co-morbid disorders, such as ADHD and the third how parental discord impacts on children. These difficulties were related to only a few group members, and as a result, should rather be addressed with individual therapists, saving the group time for more pervasive issues.

Clients struggled with concentration in discussion groups. As the clients recommended shorter groups, it is recommended that when the South African billing codes are reviewed, the inclusion of time-based codes would allow therapists more flexibility in terms of the clients' capacity. Therapists should also adjust groups to accommodate clients' concentration difficulties by the inclusion of topic related relevant warm-ups, changes of pace and activities during the session.

As per clients' suggestions, it is recommended that therapists make greater use of technology such as projectors to present video clips of life skills training to allow multimedia input to make sessions more interesting.

The limitations of the study relate to this being a small study focusing on the content of one week of the programme and limited to one site. Much further research is needed in this area to gain a clearer understanding of what is best practice for occupational therapists working with MHCUs with very limited contact time, to make the greatest impact on their clients' lives.

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CHAPTER 3: SYNTHESIS

3.1 SUMMARY OF CONCLUSIONS

As a therapist working in the study setting, this data set effectively represents the experience of many of the clients treated in the setting, and concurs with many of the stories of pain and struggle that we hear daily within our clinic and within the greater South African population. The participants described the pain of downward cycles of deteriorating relationships, and symptoms of poor mental health exacerbated by the stigma of having a mental health disorder.

These cycles appear to start to reverse as a result of more honest and supportive relationships developed within the groups, in a supportive, non-judgmental environment, where new skills are taught, practiced and applied. Engagement in occupation or meaningful activity assisted participants to integrate these skills. Even during this acute stage of treatment, the effects of the improvement in the individual can start to have a positive impact on their relationships and family systems. This occurs through the process of empowering participants to make choices to leave, change or accept their life situations, and understanding the consequences of these decisions.

This study reinforces the importance of occupational therapy group work within the context of mental health care, in terms of both the therapeutic benefit of meaningful activity, and the value of interpersonal learning during group therapy. The findings compel occupational therapists to remain true to our foundations, our belief that meaningful activity has both intrinsic and therapeutic value, which can provide both intra and interpersonal healing. Occupational therapists need to internalise this principle and continue to include occupation, or activity into occupational therapy groups, not just activity, but purposefully chosen activity, with meaning and significance to the clients' needs and context.

The value of the therapeutic group has been well described in literature (Finlay, 1993; Yalom *et al.*, 2005; Corey *et al.*, 2008) with which the findings of this study concur. In

the South African context, where there is a “substantial gap between the demand and supply of mental health services” (The Department of Health, 2013, p. 3), this modality of care is of great significance, as it is both effective and efficient in terms of South Africa’s limited resources.

3.2 OUTCOMES OF OBJECTIVES

The study initially outlined five objectives. The first objective explored the difficulties that participants were having in their interpersonal relationships. The participants clearly described their relationship difficulties during the focus groups. They shared their frustrations of living in maladaptive relationships and identified factors impacting on these relationships. Two interesting lessons came out of this objective. Firstly, despite coming from South Africa, a country with many socio-economic struggles, the participants described very similar difficulties to those described in literature in studies set in western countries.

Despite this similarity, the participants’ daily struggles and relationship difficulties were also particularly nuanced due to their immersion in the South African context. This was not discussed within either journal article due to the focus of these articles and the word limit constraints. The South African context and its impact on mental health are significant for the treatment of MHCU’s in South Africa. As discussed in the literature review, South Africans live in a context of violence, rape, abuse, increasing crime, escalating HIV infections, high male infidelity, dispersed families, high unemployment rates and financial strain (Wojcicki, 2002; Hölscher, 2008; Gibson, 2012; Harrison *et al.*, 2012; Bennett *et al.*, 2015). Living in this context impacted on the participant’s relationships and on their abilities to use their communication skills effectively. Sné describes how she sought emotional support from her partner’s parents, but they did not provide it as they were afraid of losing his financial support: “*parents won’t be supportive… the way I need coz at the end they need him to support them you see.”* Participants discussed their romantic partners infidelity (both suspected and experienced) as one of the difficulties that they were facing. Thandiwe described her initial response to this: *“he was cheating but um, I’m not a… I’m not a*

confronting person". In this context high levels of male infidelity mean that many women expect their partners to be cheating and are advised by their family members and friends to accept it, despite their pain and hurt.

The second lesson from this objective is that stigma has a significant negative impact on participants' relationships both at home and in the workplace. The participants' relationships seemed to be impacted both by social stigma and internalised stigma. Participants had experiences of being judged and disregarded by others, due to their diagnosis of having a mental health disorder, this impacted on their ability to have a voice in their homes and the community. The internalised stigma also impacted on the MHCUs' relationships as they held to some of the prejudices around mental health themselves. These beliefs prevented them from making attempts to communicate effectively.

The second objective explored the change in clients' relationships as a result of participation in group therapy. These changes have been explored and described in the body of article 1. Of great significance was that despite the fact that the participants were admitted for intervention at the time of the focus groups, some were already experiencing improvement in relationships through improved communication.

Objective three targeted the efficacy of the groups and the interplay between the multi-disciplinary team. It was surprising to find that many participants did not even notice that they were working with clinicians from different professions. The outcomes of this objective are largely discussed in article two.

The discussion related to objective four forms the middle section of article 1, describing the groups, how the group dynamics effected healing in the here and now, and the final section of article two, describing the development of trust and cohesion in the group and group norms.

The final objective of the study was to identify areas in which the programme was lacking, and encourage the participants to assist in co-creating the group intervention. It was interesting to find the participants, in this acute stage of therapy, commented more on the structure of the timetable and desire for activity and less on actual group content and skills or missing content.

The objectives, and as a result the aims of this study, have been successfully met. However, the outcomes of some of these aims are surprising and different from what the researcher expected.

3.3 PERSONAL REFLECTION

3.3.1 Research content:

For me, as a group therapist, this study has been very valuable. The study has shifted my focus in therapy away from trying to ensure that the groups cover all of the clients' needs in terms of building skills to improve functioning in relationships and in life at this stage of treatment. I realise that it is more important for the client to experience healing relationships through group dynamics and authentic experience than to learn about the theory. The content of the group can be very useful and significant; however, this is not the most important factor, and will probably not be what the clients remember in the long term.

I have been reminded of the importance of activity, and been reenergised to include more creativity and activity into my therapy. One's energy and creativity becomes sapped in a busy schedule with clients' great emotional needs, leading to a slow dropping off of warm-ups, new ideas, and creativity. The value of these has been reinforced by this study, and I am inspired to be more creative, and include more doing and less talking in my groups as a result. As a therapist, developing a greater level of trust in the vehicle of group therapy and in the great value of purposeful occupation, will continue to deepen the quality and efficacy of my groups. To prevent the slow reduction of creativity in the future, I plan to try to schedule more planning time in the week and continue reading journal articles around groups.

3.3.2 Research process:

The experience of conducting research was a positive one, as it forced me to move from planning to read literature to actually reading research and hunting for information on group therapy and as a result, learning. The process of starting with a real question and finding a way to answer this question has been gratifying and exciting not only for me but for my colleagues, who are finding the study findings encouraging.

As much as the study has answered questions, it has left me with many more questions, such as a desire to understand the impact of the other two themes during our therapy programme. During the study, I dreamt of broadening this study, and it would very interesting to do a similar study at a number of sites comparing different client groups and therapy programmes, to gain a better idea of best practice and better understand the transferability of this study.

The process of research, editing, and rewriting has forced me to improve my critical thinking and writing skills. As I have looked back at my original proposal I am able to see the improvement in writing skills. These skills will be of benefit to me not only as a researcher and therapist, but also personally.

3.4 RECOMMENDATIONS

3.4.1 Recommendations for research

As discussed extensively in this paper, mental health disorders are a significant global challenge making the effective treatment of MHCU an urgent and vital matter. Occupational therapists as key role players in this area need to be well versed with research on which to base our best practice. This paper only begins to address these needs; and much further research is needed in this important area to understand the MHCU's needs at different stages of treatment and how occupational therapists can best meet these needs. Research also needs to be directed at understanding the effects of policy, and medical aid cover for the MHCU's sustained recovery.

3.4.2 Recommendation for the study site:

Recommendations for the study site and thus similar study sites have been discussed in detail in the articles, some of these include the use of audio-visual equipment such as projectors, the spread of content throughout the programme, instead of within a focused week and the interaction within the multi-disciplinary team to limit the number of groups clients miss, as this impacts on their confidence to use life skills. Given the similarities noted between the participants in the study site and those in the western countries, these recommendations could possibly be applied beyond the borders of South Africa.

The findings of the study also highlight the nuances of living in the South African context; participants cited some of these issues as negatively impacting both their mental health and their relationships. This requires occupational therapists in South Africa to include groups into their programmes that discuss the issues specific to the South African context, such as issues of chronic physical illness, stigma, relationships with money and money management.

These are long-term and entrenched problems that speak to peoples' lived realities. Short-term therapy, in an acute unit, only starts to assist the clients to resolve the current crisis, but does not begin to address the larger systemic difficulties, or support sustained change. The process of the literature review and the data analysis has reinforced the magnitude of the gap in care in the private sector in South Africa after the clients' discharge from hospital. The study shows that clients start to show growth in their understanding of their maladaptive interpersonal styles and start to develop more adaptive interpersonal styles, through occupational therapy groups. MHCUs however, cannot consistently apply the skills that they gain in therapy, and are aware that the road to recovery will be a long one. Further support post-discharge is therefore, important to make a sustained impact on individual lives. The hospital and hospital group, in which this study was based, have make effort to start filling this gap through the telephonic follow-up of at-risk clients and the introduction of free, post-discharge groups aimed at supporting change and reinforcing skills learnt during

admission. However, the needs described in the study, far outweigh support currently offered by the health system in South Africa.

3.4.3 Recommendations for health systems and policy

The occupational therapy position statement on therapeutic group work discusses the role of the occupational therapist in asking questions (Occupational Therapy Association of South Africa, 2014); this section could be elaborated on, as a result of these findings. The role of the occupational therapist is greater than developing and activity and asking questions, but importantly extends to the development of rapport, modelling adaptive behaviours, and a trusting therapeutic relationship.

The National Mental Health Policy Framework and Strategic Plan 2013-2020 describes a vision of “improved mental health for all in South Africa by 2020” (The Department of Health, 2013, p. 19). This policy describes the significant economic and social costs of mental health problems in South Africa, and argues that is it more expensive not to treat people with mental health illness, than it is to offer treatment to those with mental health difficulties. This study shows that occupational therapists are able to play a key role in working towards this vision in a cost effective way. As a result it is strongly recommended that the employment of more occupational therapists become a priority nationally in both the state and private sector. This requires the reopening of frozen posts and further job creation especially in community and primary health care, where occupational therapists can assist clients to make sustainable, long term improvements in their lives.

South Africa requires both state and private sectors to prioritise mental health care in the effective treatment of MHCU’s (Parliament of South Africa, 2014). This study has shown that occupational therapy group work is a part of an effective treatment plan for MHCUs. Greater investment into research in this area, and development of sustainable occupational therapy programmes in South Africa are vital to start to contain the growing and pervasive challenge that mental health care presents in the world today.

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APPENDIX A: INSTRUCTIONS' TO STUDENTS ON MASTERS BY MANUSCRIPT:

Outline of thesis:

Preliminary pages

i. Title page
ii. Preface and Declaration
iii. Dedication
iv. Acknowledgements
v. Table of contents
vi. List of figures, tables and acronyms (separately presented)
vii. Abstract

Main Text

1. Chapter 1: Introduction (2000 words)
    Introduction including literature review
    Research questions and/or objectives
    Brief overview of general methodology including study design

2. Chapter 2 (5000-6000 words)
    First manuscript/publication

3. Chapter 3 (5000-6000 words)
    Second manuscript/publication

4. Chapter n
    Final manuscript/publication

5. Chapter n+1: Synthesis (1700 words)
    Synthesis
    Conclusions
    Recommendations

6. References Appendices

NB. Between the manuscripts or publications there must be a 1 page (maximum) bridging text to demonstrate the link between them

APPENDIX B: SEMI-STRUCTURED QUESTIONS FOR THE FOCUS GROUPS

1. Before you were admitted what wasn't working in your relationships with others?
   Prompts: Were you able to ask for help?
   Were you able to manage conflict?
   Were you able to express your needs?
   Were you able to listen to others and respect their needs?

2. What have you learnt about your relationships this week? What happened that helped you to discover this?

3. What has happened in the group that has helped you to understand your relationships outside the group?

4. Can you see any changes in yourself and how you are with other people?

5. What do you think helped you to change? Did you have any moments in the week that stand out as important?

6. What changes would you like to see in yourself in how you relate to others?

7. Have you tried to use any of the things that you learnt in groups this week? What happened? What do you think would happen if you tried any of these ideas?

8. If you had to rate the groups you attended this week, which groups/activities would you say helped you the most?
   Prompt: What did you find unhelpful?
   Were the groups that you enjoyed the same as the groups that you found useful?
   Did you find role play groups more or less, helpful than theory or lecture style groups?

9. What was the experience of being in a group like?
   Prompt: What made it easier for you to share?
   Did you trust others in the group?
   What did you gain from other group members?
   What was the experience of being a group member like?
   Did you feel that you belonged?
   What did you feel about the size of the groups?

10. What else would you have liked to deal with in groups on relationships this week?
    Prompt: Are there any of the areas that you struggled with when you were admitted that you haven't had the chance to look at here?

11. What do you think would improve the groups?

12. During the week you have had individual therapy and group therapy. How have you found the differences between the two?
    Prompt: What was better in group therapy?
    What was better in individual therapy?

13. During the week you have had both psychology groups and OT groups? How have you experienced the two kinds of groups?
    Prompt: How did OT groups differ from other professionals such as psychologist/ psychiatrist?

14. What thing did you find most valuable in groups this week?

School of Health Sciences

Discipline of Occupational Therapy

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Telephone: 031 260 8218

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APPENDIX C: INFORMATION LETTER TO PARTICPANTS

Student: Andrea Radnitz (082 564 98490)

Supervisors: XXXXXXX (0000000),

XXXXXXXX

Biomedical Research Ethics Administration, Westville Campus, Govan Mbeki Building, Private Bag X 54001, Durban, 4000, KwaZulu-Natal, South Africa; Tel: +27 31 2602486; Fax: +27 31 2604609; Email: BREC@ukzn.ac.za

Date: 1 July 2016

My name is Andrea Radnitz from the University of KwaZulu-Natal, Occupational Therapy department. Contact details can be found above.

You are invited to consider participating in a study that involves understanding client's perceptions of Occupational therapy groups.

Purpose and aim

The aim and purpose of this study is to investigate clients' thoughts on Occupational therapy groups on the theme of relationships and to find out which groups are the most helpful and which are in the clients' opinion are unhelpful.

The research involves attending a group discussion, called a focus group, to talk about your experiences of groups in the week. This discussion will take no more than 90 minutes and refreshments will be provided.

The study will assist therapists to have a richer understanding of clients' experiences of group therapy and may help to further develop this and other Occupational therapy programme in the future.

Risks

There are no known risks associated with participation in the study

Ethical consideration

All information that is collected will be handled in the strictest confidence. No individual identifiable information will be released to any other person. All data will be stored securely, with only the researcher and supervisors having access to it.

Research findings may be submitted to a scientific journal for publications and or presented at research congresses, which may lead to identification of the facility, but not of individual participants.

Your participation in the study is completely voluntary. You will not lose any benefits or potential benefits should you decide not to participate in the study. You may also withdraw from the study at any stage.

This study has been ethically reviewed and approved by the UKZN Humanities and Social Science Research Ethics Committee. (Approval number _BE208/16_) Contact details can be found above.

In the event of any problems or concerns/questions you may contact the researcher on 082 564 9849 or the UKZN Humanities and Social Science Research Ethics Committee on 031 260 4557.

Your participation would make an invaluable contribution to the research and I would greatly appreciate your involvement.

Sincerely

_____

Andrea Radnitz

Department of Occupational Therapy

University of KwaZulu-Natal

School of Health Sciences

Discipline of Occupational Therapy

Postal Address: Private Bag X54001, Durban, 4000, South Africa

Telephone: 031 260 8218

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APPENDIX D: INFORMATION LETTER TO THE STUDY SITE

Student: Andrea Radnitz (082 564 9849)

Supervisors: XXXXXX (00000000),

XXXXXX

HUMANITIES & SOCIAL SCIENCES RESEARCH ETHICS ADMINISTRATION: Research Office, Westville Campus, Govan Mbeki Building, Private Bag X 54001,Durban, 4000, KwaZulu-Natal, SOUTH AFRICA, Tel: 27 31 2604557- Fax: 27 31 2604609, Email: HSSREC@ukzn.ac.za

Date: 18 February 2016

My name is Andrea Radnitz from the University of KwaZulu-Natal, Occupational Therapy department. Contact details can be found above.

I would like to conduct a study of how clients perceive and experience Occupational therapy groups. I request that I conduct this study in your clinic.

Purpose and aim

The aim and purpose of this study is to investigate clients' perceptions of Occupational therapy intervention groups which facilitate the remediation/maintenance/strengthening of interpersonal relationships. Secondly to identify which elements or groups they believed were the most beneficial

and assisted them to learn or grow the most effectively and which aspects they perceived to be ineffective or unhelpful.

I believe that this study will be of benefit to your clinic as it will assist in gaining a greater understanding of the client's needs and opinions and will assist to inform future programme development.

The research involves 3 focus groups being conducted on the property with the clients at a time that is convenient to you and your clients and that is outside of their usual group time.

Risks
There are no known risks associated with participation in the study

Ethical consideration
All information that is collected will be handled in the strictest confidence. No individual identifiable information will be released to any other person. All data will be stored securely, with only the researcher and supervisors having access to it.

Research findings may be submitted to a scientific journal for publications and or presented at research congresses, which may lead to identification of the facility, but not of individual participants.

This study has been ethically reviewed and approved by the UKZN Humanities and Social Science Research Ethics Committee. (Approval number _BE208/16_) Contact details can be found above.

In the event of any problems or concerns/questions you may contact the researcher on 082 564 9849 or the UKZN Humanities and Social Science Research Ethics Committee on 031 260 4557.

Your participation would make an invaluable contribution to the research and I would greatly appreciate your involvement.

Sincerely

_____

Andrea Radnitz

Department of Occupational Therapy

University of KwaZulu-Natal

School of Health Sciences

Discipline of Occupational Therapy

Postal Address: Private Bag X54001, Durban, 4000, South Africa

Telephone: 031 260 8218

UNIVERSITY OF KWAZULU-NATAL

INYUVESI YAKWAZULU-NATALI

APPENDIX E: INFORMED CONSENT FORM, ENGLISH

Consent Form:

Dear potential participant,

Study Purpose

You are being asked to take part in a research study being conducted by a researcher from the University of KwaZulu-Natal. This study is exploring clients' perceptions of Occupational therapy groups. The purpose of this study is to improve Occupational therapy services and Occupational therapists understanding of clients and their experiences of group work.

Procedures

If you decide to take part in this study, a researcher will conduct a focus group (group discussion) with you and a group of other clients. This focus group should not take longer than one and a half hours. The focus group will be audio recorded for later transcription purposes. All information obtained from you will be kept strictly confidential. We ask other members in the group to also maintain this confidentiality.

Risks, Discomforts & Inconveniences

Please also remember that we keep this information absolutely confidential: none of the information you reveal will be publically linked to your name and will in no way negatively impact on your treatment in this clinic at this or future admissions.

Benefits

If you participate in this research, you will assist in providing understanding that may be used in the future to improve the quality of Occupational therapy services in this clinic.

Voluntary Participation

Participation in this study is completely voluntary. You are free to refuse to answer any question. Your decision regarding participation in this study will not affect your relationship with this clinic and or services you might access at the clinic. If you decide to participate, you are free to change your mind and discontinue participation at any time during the group discussion.

Privacy and Confidentiality

We will take strict precautions to safeguard your personal information throughout the study. Your information will be kept without your name or other personal identifiers. The group interview will take place in a private room. Any reports or publications about the study will not identify you or any other study participant.

Questions

If you have questions, concerns, or complaints about the study or questions about a research-related query, please contact

1. Researcher: Andrea Radnitz 082 564 9849
2. Supervisor: XXXXXXXX 000 00000
3. Biomedical Research Ethics Administration, Westville Campus, Govan Mbeki Building, Private Bag X 54001, Durban, 4000, KwaZulu-Natal, South Africa; Tel: +27 31 2602486; Fax: +27 31 2604609; Email: BREC@ukzn.ac.za

If you have any other questions or concerns about this study, please feel free to contact the Department of Occupational Therapy at UKZN 000-0000

Signatures

I, the researcher, have explained the above verbally and given the potential research participant time to ask any questions they may have. They have been given a copy of this consent form.

_____ _____

Researcher's Signature Date

I, _____have been informed about this research study and understand its purpose, possible benefits, risks, and discomforts. I agree to take part in this research as a subject. I know that I am free to withdraw this consent and leave this project at any time, and that doing so will not cause me any penalty or loss of benefits that I would otherwise be entitled to enjoy. I have been given time to ask any questions and these questions have been answered to the best of the investigator's ability.

_____ _____

Subject's Signature Date

I understand that the focus group discussion will be audio-recorded and then transcribed. I understand that only the researchers will have access to the tape and to the transcriptions. I agree to the recording of the group's discussion.

_____ _____

Subject's Signature Date

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INYUVESI YAKWAZULU-NATALI

APPENDIX F: INFORMED CONCENT FORM, ISIZULU

CONSENT FORM

Kulowo ozobamba iqhaza,

INJONGO YESIFUNDO

Uyacelwa ukuba ube ingxenye yenhlolovo eyenziwe ngaphansi kwe Nyuvesi yakwa Zulu-Natal. Lesisifundo sizobheka indlela iziguli eziqonda ngayo amaqembu aqhutshwa ilabo abelapha ngokusebenza (Occupational Therapy groups) kanye nemibono ngalamaqembu.

INDLELA YOKWENZA

Uma uvuma ukuba ingxenye yalenhlolovo, umhloli (researcher) uzosungula ithimba elizoxoxa, nawe kanye nabanye ababambe iqhaza (group discussion). Lelithimba lizothatha isikhathi esingeqile kwi hora nengxenye. Lelithimba lizoqoshwa ukuze elikuxoxile kubhalwe phansi kamuva. Yonke into ozoyiveza kulengxoxo ayizukudluliselwa komunye umuntu ngaphandle komhloli. Nalabo abayingxenye yethimba bazocelwa ukuba lokho okukhulunyiwe kube yisifuba sabo.

UBUNGOZI

Khumbula ukuthi konke okukhulunyiwe akuzudalulwa furhi negama lakho alizuvezwa, ngakhoke ukwelashwa kwakho ngeke kuphazamiseke noma kunini noma uphinda uzolaliswa kulesisikhungo.

UBUHLE

Uma uyingxenye yalelithimba uzobe ulekelela ukuba siqonde izindlela esingathuthukisa ngazo amaqembu okwelapha ngokusebenza (occupational therapy) kulesiskhungo.

UKUZINIKELA KWAKHO

Ukubamba iqhaza kulesisifundo akuphoqiwe. Uvumelekile ukwenqaba ukuphendula eminye yemibuzo. Futhi akuzuphzamisa ubuhlobo bakho nalesisikhungo. Uma uyingxenye yalelithimba, ungakwazi ukushintsha umqondo uphume noma inini kulesisifundo.

UKUVIKELEKA

Sizothatha izinyathelo ezinqala ukuba igama lakho nakhokonkenokuthinta ubuwena kuvikeleke kulesisifundo. Ithimba lizohlanganela endaweni esithile, kude nabanye abntu. Imibiko nezethulo akuzuveza ubunjalo kanye namagama abantu.

IMIBUZO

Uma unemibuzo, ukukhathazeka noma izikhalazo ngalenhlolovo ungathinta laba abalandelayo:

1. Researcher: Andrea Radnitz 082 564 9849
2. Supervisor: XXXXXXXXX 000000000
3. Biomedical Research Ethics Administration, Westville Campus, Govan Mbeki Building, Private Bag X 54001, Durban, 4000, KwaZulu-Natal, South Africa; Tel: +27 31 2602486; Fax: +27 31 2604609; Email: BREC@ukzn.ac.za

Eminye imibuzo kanye nokukhathazeka mayelana nalesisifundo ungakuyisa ngqo kumnyango we Occupational Therapy eNyuvesi UKZN 000000.

UKUSAYINA

Mina njengonhloli, ngimuchazele lowo ozobamba iqhaza kulesisifundo, ngaphendula nemibuzo ebebenayo. Yena unikeziwe ikhophi yalelifomu ukuba aligcine.

_____ _____

Researcher's Signature Date

Mina, ngichazeliwe ngalenhlolovo, ngayiqonda injongo, ubungozi, nobuhle obungenzeka ngenxa yayo. Ngiyavuma ukuba ingxenye yayo. Ngiyazi ukuthi ngingahoxisa noma kunini uma ngifisa, futhi lokho akuzuwaphazamisa nakancane amalungelo ami. Nginikeziwe isikhathi sokubuza, futhi ngaphenduleka ngokwenelisayo.

_____

Subject's Signature Date

Ngiyaqonda ukuthi izingxoxo zizoqoshwa (audio- recording) ukuze zibhalwe phansi. Ngiyqonda futhi ukuthi okuzovela kulezizingxoxo kuzogcinwa kahle umhloli kungaweli ezandleni ezingafanele. Ngiyavuma ukuba okuzoxoxwa ithimba kuqoshwe.

_____ _____

Subject's Signature Date

APPENDIX G: BIOGRAPHICAL QUESTIONAIRE

Focus group number: | |

Participant no: | | |

Biographical Questionnaire:

It would be appreciated if you could take some time to complete this questionnaire. All information given will be treated as **strictly confidential** and will only be reported on collectively or as a group, e.g. 40% of participants were female.

Preferred Pseudonym: _____

Please answer the questions below by placing an X in the appropriate box.

1. Gender: Male □ Female □

2. Age: _____

3. Marital status: □ single □ married □ widowed □ divorced/separated

4. Other Please Specify_____

5. How many people are living in your household, including yourself?

   □1 (yourself) □2 □3 □4 □5 □6 or more people

6. Home Language: □English □IsiZulu □IsiXhosa

   Other Please Specify_____

7. Proficiency in English

   □Very Good □Good □Average □Bad
   □Very Bad

8. What level of schooling did you complete? If more apply, select the **highest** one.
   - □Primary school (grade 1 to 7)
   - □Secondary school (grade 8to10)
   - □High school (grade 11 -12)
   - □Tertiary education (university, technikon or Technical College)
   - □not yet graduated
   - □Postgraduate studies

9. Which of the following statements about occupational status apply to you?
   - □Not working at the moment
   - □Part-time or hourly work (< 15 hours per week)
   - □Part-time work (15 to 34 hours per week)
   - □Full-time work
   - □In training (apprentice or internship)
   - □Currently studying

10. If yes to working on the above, what is your **present** occupational position or (if no longer working) was your **last** position?

    □Unskilled Labourer □trained on the job □skilled
    □professional □Self-employed □None of the above

11. How many times have you been admitted to hospital for mental health difficulties, including this current admission?

    □ 1 (This current admission) □2 □3 □4 □5 □6 or more

12. For how many days have you been admitted in this current admission? __ _____days.

13. Was your admission prompted by your friends, family or Doctors suggestion or by your own request?
    □ Friends and family □Doctor or therapist □Self

14. In your own words, which difficulties are you seeking assistance in this admission?
    _____
    _____
    _____

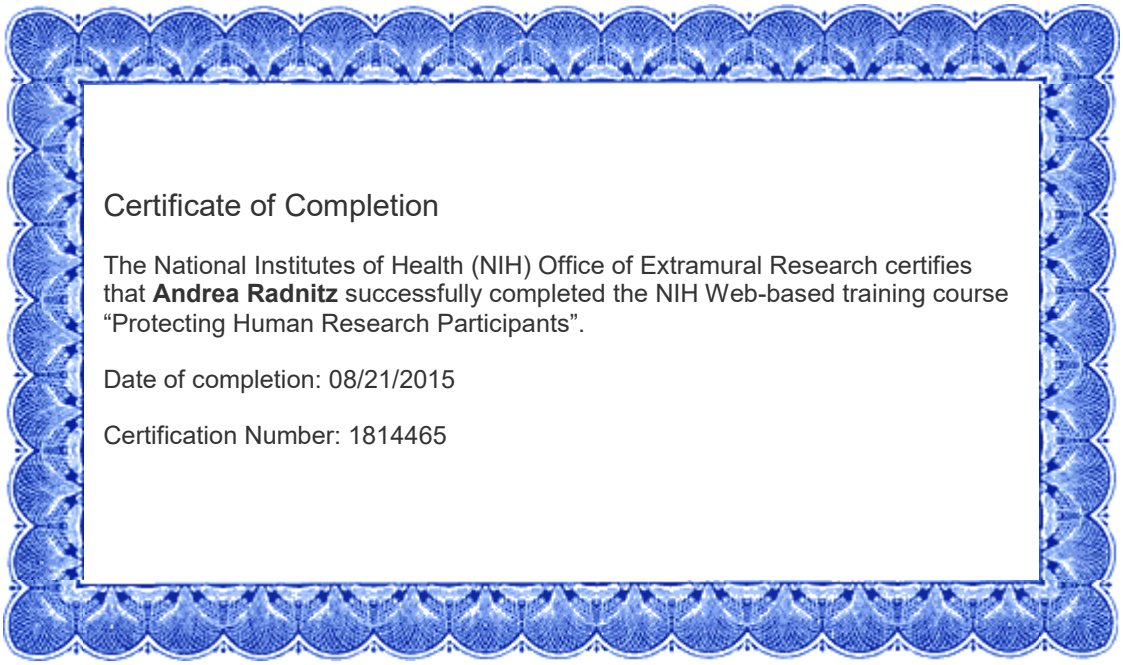
15. Do you have interpersonal relationship difficulties? (e.g. problems with your relationship with your romantic partner, superiors at work, parents or friends and extended family.)

□Yes □No

16. If "yes" please describe some of the difficulties you experience below.

Thank you very much for providing these details.

APPENDIX H: ETHICS CERTIFICATION



Certificate of Completion

The National Institutes of Health (NIH) Office of Extramural Research certifies that **Andrea Radnitz** successfully completed the NIH Web-based training course "Protecting Human Research Participants".

Date of completion: 08/21/2015

Certification Number: 1814465

APPENDIX I: BREC APPROVAL LETTER

UNIVERSITY OF KWAZULU-NATAL
INYUVESI YAKWAZULU-NATALI

07 June 2016

Mrs A Radnitz (9804482)
Discipline of Occupational Health
School of Health Sciences
andrea@radnitz.co.za

Dear Mrs Radnitz

Protocol: Client perception of Occupational Therapy intervention groups in an acute psychiatry setting.
Degree: M Occupational Health
***BREC reference* number:** BE208/16

The Biomedical Research Ethics Committee has considered and noted your application received on 15 March 2016.

The study was provisionally approved pending appropriate responses to queries raised. Your response received on 25 May 2016 to queries raised on 14 April 2016 have been noted and approved by a sub-committee of the Biomedical Research Ethics Committee. The conditions have now been met and the study is given **full ethics approval.**

This approval is valid for one year from **07 June 2016.** To ensure uninterrupted approval of this study beyond the approval expiry date, an application for recertification must be submitted to BREC on the appropriate BREC form 2-3 months before the expiry date.

Any amendments to this study, unless urgently required to ensure safety of participants, must be approved by BREC prior to implementation.

Your acceptance of this approval denotes your compliance with South African National Research Ethics Guidelines (2015), South African National Good Clinical Practice Guidelines (2006) (if applicable) and with UKZN BREC ethics requirements as contained in the UKZN BREC Terms of Reference and Standard Operating Procedures, all available at http://research.ukzn.ac.za/Research-Ethics/Biomedical-Research-Ethics.aspx.

BREC is registered with the South African National Health Research Ethics Council (REC-290408-009). BREC has US Office for Human Research Protections (OHRP) Federal-wide Assurance (FWA 678).

The sub-committee's decision will be RATIFIED by a full Committee at its meeting taking place on 12 July 2016.

We wish you well with this study. We would appreciate receiving copies of all publications arising out of this study.

Yours sincerely

[redacted]

Professor J Tsoka-Gwegweni
Chair: Biomedical Research Ethics Committee

cc supervisor: christopherc@ukzn.ac.za
cc Postgraduate office: nenep1@ukzn.ac.za

APPENDIX J: GROUPWORK JOURNAL: NOTES FOR AUTHORS ON MANUSCRIPT SUBMISSION

The following notes are intended to help authors following final acceptance of their article. Following these procedures will speed up publication and also reduce the chance of typesetting errors.

1. Authors should type the text without attempting to reproduce look and feel of the final typeset page.

2. Authors should leave a clear line between paragraphs (ie two carriage returns). Two clear lines should be left before headings and subheadings. Two clear lines before and after quotations not embedded in paragraphs and before and after series of numbered or bullet points.

3 Authors should try to restrict themselves to two or at most three levels of subheading. The level of each heading should be made clear on the hard copy provided.

4. Our house style uses capital letters sparingly. Authors should use lower case for headings and subheadings with capitalised initials only for the first word and for proper nouns. Headings should not be typed all in capitals. Capital initials should not be used for Awful Emphasis.

5. We never use bold type in text. Book and journal titles, foreign words which retain their foreign force (but not those which have been effectively absorbed as English words), and phrases requiring emphasis are italicised. Authors should indicate text to be italicised consistently by either underline or italic.

6. We never use italics for embedded quotes (up to 25 words). Authors should present quotes of more than 25 words as free standing paragraphs typed in Roman with opening and closing quotation marks. Shorter quotations should be run in to the paragraph with opening and closing single quotation marks. Double quotation marks should only be used for quotes within quotes. Quotation marks should not be used to mark off book titles - these should be italicised or underlined.

7. Bullet points may be indicated by an asterisk followed by a tab. There is no need for authors to attempt to reproduce the appearance of hanging indents etc as we do that automatically on typesetting. Bullet points should be used in preference to numbered points unless there is an issue of sequence or priority. Our style of numbering is as used here, following the number by a period and a tab, not a bracket. Do not use Roman numbers for numbered points, except in the very rare circumstances where it is truly necessary to have subsets of numbered points.

8. Footnotes should never be used. End notes may be used if absolutely necessary. Authors should avoid presenting notes using the footnote command on their word processing systems as this text does not always easily translate over. Footnotes should be extracted and added to the end of the article as part of the main text. Endnotes should be numbered like numbered points above. The reference numbers in the text may be in superscript so[1], or between square brackets so [1].

9. Harvard referencing is to be used. References within text should be cited by giving the author's name and year of publication, eg. (Smith, 1928), or (Smith, 1989; Jones, 1967). Specific page numbers should be cited after a direct quotation. A reference list should appear at the end of the manuscript, and should include only those references cited in the text. References should be provided in alphabetical order, using the conventions below. Author's names are to be in upper and lower case, not capitals. There are significant differences from one publisher to another in the exact application of the Harvard conventions. Please note carefully our use of capitalisation, italics, punctuation (for example, we use commas where some publishers use semi-colons, and vice versa) and position of authors' initials (after the author's name for cited author, before for editors of works in multiple authorship of which cited chapter is a part).

Books (print): author's surname, initials, date (in brackets), title of book (main title in italics, initial capitals, sub-title, initial capital first word only), place of publication, publishers. eg Pilaster, D. and Clerestory, E. (1994) Practical Practice Teaching: Using lower case in sub-titles. London: Daffodil Press

Edited Books (print): author's surname, initials, date, title of article (lower case), editor's initials and surname, title of book (in italics, capitals as for books above), place of publication, publishers, page numbers of chapter. E.g. Dirak, A. and Bauhaus, S. (1970) The practical perspective. in J. Bloggs and F. Soap (Eds.) The Future of the Practical Profession: Applying the lessons of the past. Weissnichtwo: Skolastica (pp.401-432)

Online publications other than journals: Author's name, date, title, 'publisher', date accessed and URL eg. Pilaster, D. and Clerestory, E. (1994) Practical Practice Teaching: Report of the Weissnichtswo Teaching Collaborative. Weissnichtswo Collective Group [Accessed 7 June 2011 at http://www.WTC.org/reports/1234]

Journal articles, print version: author's surname, initials, date, title of article (lower case), title of journal (italics, initial capitals), volume, issue, page numbers. eg Einstein, A. and Freud, S. (1920) The unconscious teacher. The Journal of the Future, 24, 2, 101-124

Journal articles, online version: author's surname, initials, date, title of article (lower case), title of journal (italics, initial capitals), volume, issue, page numbers (if any - only relevant for .pdf and similar formats which maintain paging), date material accessed, URL. Please note date style and use of square brackets eg Einstein, A. and Freud, S. (1920) The unconscious teacher. The Journal of the Future, 24, 2, 101-124 [Accessed 7 June 2011 at http://www.wildblueyonder.org/journals/TJF/24/2/002]

Publications from the same author in a single year should use a,b,c etc. Where there are more than two authors the reference within text should be cited using et al, eg. (Smith et al, 1928), and the names of all authors should be included in the reference list. Spelling in the reference list should follow the original.

Only works actually cited in the text should be included in the references.

Appendix K Letter of receipt of journal article:

[Groupwork] Submission Acknowledgement **Sept 30**

to me

Mrs Andrea Jean Radnitz:

Thank you for submitting the manuscript, "The insider perspective: Occupational group therapy process and content in an acute mental health facility" to Groupwork. With the online journal management system that we are using, you will be able to track its progress through the editorial process by logging in to the journal web site:

Manuscript URL:
https://journals.whitingbirch.net/index.php/GPWK/author/submission/1076
Username: andrearadnitz

If you have any questions, please contact me. Thank you for considering this journal as a venue for your work.

David Whiting
Groupwork

Groupwork
http://journals.whitingbirch.net/index.php/GPWK