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IMPLICATIONS OF TEMPORARY INCAPACITY LEAVE ON SPECIFIC MENTAL FUNCTIONS AMONG INDIVIDUALS DIAGNOSED WITH A COMMON MENTAL DISORDER

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A Dissertation Submitted to the Faculty of Health Sciences, University of The Witwatersrand, Johannesburg, In Fulfilment of The Requirements for The Degree of Master of Science in Occupational Therapy.

JOHANNESBURG

2025

DECLARATION

I, Annemiek Meyer, hereby declare that this dissertation is my own work. It is being submitted for the degree of Master of Science in Occupational Therapy at the University of the Witwatersrand, Johannesburg. It has not been submitted before for any degree or examination at this or any other university.

Signature 

Date: 04/06/2025

DEDICATION

This dissertation is dedicated to God the Almighty Father, the source of all wisdom and knowledge, for granting me strength, guidance, and inspiration throughout this research journey. May my work bring glory to Your name, and may it serve as a testament to Your grace.

.

ACKNOWLEDGEMENTS

I would like to express my deepest gratitude to the following individuals who have contributed to the completion of this research project:

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- The University of Witwatersrand's Occupational Therapy department for providing me with the opportunity to pursue my research goals.
- My employer for allowing me to use client records from the practice.

ABSTRACT

Introduction: Common mental disorders (mood, anxiety, posttraumatic stress disorder and substance use disorder) are prevalent within the South African population and have a significant burden on the labour market. Symptoms of common mental disorders may lead to temporary psychosocial disability, and employees may need temporary incapacity leave. Prolonged temporary incapacity leave prevents the employee from experiencing the beneficial aspects of work, and early return to work is known to promote mental health and recovery from common mental disorders. **Research Aim**: This research aimed to explore the effects of temporary incapacity leave (3-24 months) on specific mental functions among those persons diagnosed with common mental disorders, as well as the severity of symptoms that influenced return or non-return to work in the Eastern Cape, South Africa.

Methodology: A quantitative retrospective ten-year record review analysed the data obtained, which included non-identifiable demographical information as well as scores from the Zung Self-Report Anxiety or Depression Scale, the Hospital Anxiety and Depression Scale, and the Repeatable Battery. Data was analysed using descriptive and correlation statistics. **Results**: Scores indicated below-average cognitive functioning and high levels of anxiety and depression at baseline. Correlation statistics indicated that visuospatial/ constructional skills and attention declined with clinical relevance. A negative weak correlation was found, indicating that anxiety and depression symptoms were unrelated to the times of the assessment. However, a moderate positive correlation indicated that the change in depression was associated with the length of time on incapacity leave between the first and the second review assessment. **Conclusion:** Recommending incapacity leave requires a holistic approach considering personal, job and environmental factors. Factors to consider when recommending temporary incapacity leave are age, nature of the disorder, profession, stress, decline in attention as well as visio-spatial skills, and lastly, the adverse effects of a loss of work identity on mood and anxiety symptoms.

Keywords: work, temporary incapacity leave, occupational performance, and occupational role.

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OPERATIONAL DEFINITIONS

Common mental disorders is a term coined by the World Health Organisation (WHO), and are a grouping of psychological conditions, that are highly prevalent within the population worldwide, consisting of: anxiety disorders (inclusive of generalized anxiety disorder, panic disorder, social anxiety, specific phobias, separation anxiety disorder, substance/medication-induced anxiety disorder and agoraphobia); mood disorders (include major depressive disorder, depressive episode, and bipolar mood disorder); and substance use disorders (Chaudhury et al., 2006; an, 2022).

Environmental factors "make up the physical, social and attitudinal environment in which people live and conduct their lives" (World Health Organisation, 2001, p. 10).

Impairments "are problems in body function or structure such as a significant deviation or loss" (World Health Organisation, 2001, p. 10).

Independence is the ability to participate without limitations in various occupational areas, such as basic and instrumental activities of daily living, work, leisure, social engagement, and sleep (American Occupational Therapy Association, 2020).

Mental functions refer to affective, perceptual, and cognitive functions (American Occupational Therapy Association, 2020).

Occupational performance is "the ability to perceive, desire, recall, plan and carry out roles, routines, tasks, and sub-tasks for self-maintenance, productivity, leisure, and rest in response to demands of the internal and/or external environment" (Ranka et al., 2011, p.1).

Occupational performance areas "are categories of routines, tasks and sub-tasks performed by people to fulfil the requirements of occupational performance roles. These categories include self-maintenance occupations, productivity/school occupations, leisure/play occupations and rest occupations. The classification of occupations into these categories is an idiosyncratic process" (Ranka et al., 2011, p.1).

Occupational performance roles" are patterns of occupational behaviour composed of configurations of self-maintenance, productivity, leisure, and rest occupations.

Person-environment performance relationships determine roles. They are established through need and/or choice and are modified with age, ability, experience, circumstance, and time". (Ranka et al., 2011, p.1).

Participation "is involvement in a life situation" (World Health Organisation, 2001, p. 10).

Participation restrictions "are problems an individual may experience in involvement in life situations" (World Health Organisation, 2001, p. 10).

Psychosocial disability refers to disability caused by mental health conditions (World Health Organisation, 2001; van Niekerk et al., 2020).

Specific mental functions are body functions that include lower and higher cognitive functions, mental functioning with sequence, emotions, and self-awareness (American Occupational Therapy Association, 2020).

Memory is the cognitive ability responsible for encoding, storing and retrieving information. Memory is subdivided into immediate and delayed memory (Kushawha, 2024).

Visuo-spatial/ constructional skills abilities are the process of comprehending and manipulating visual information on a 2-dimensional and/ or 3-dimensional level. Furthermore, it is the ability to judge depth, navigate distance and perform visuo-spatial construction (Sasikumar et al., 2014).

Language is the ability to understand and comprehend spoken/ verbal and non-verbal forms of communication (Oviogun et al., 2020).

Attention is the ability to maintain focus on a task at hand for the duration of the task (Lindsay, 2020).

Temporary incapacity leave is granted if the employee is temporarily disabled by a medical condition (Department of Labour, 1998).

Permanent incapacity leave is granted if the employee is permanently disabled by a medical condition (Department of Labour, 1998).

Vocation refers to work or an individual's career (American Occupational Therapy Association, 2020).

Vocational reintegration is the process of returning to work after a period of extraction. (American Occupational Therapy Association, 2020).

ACRONYMS

Abbreviations	**Full name**
RBANS	The Repeatable Battery for the Assessment of Neuropsychological Status
MCID	Minimal Clinical Important Difference
HADS	Hospital Anxiety and Depression Scale
SDS	Zung Self-Rating Depression Scale
SAS	Zung Self-Rating Anxiety Scale
TIL	Temporary Incapacity leave
PIL	Permanent Incapacity Leave

CHAPTER 1: INTRODUCTION

1.1 Introduction and background to the study

Common mental disorders have a high prevalence globally as well as in the South African population (World Health Organisation, 2017). A study on the global burden of disease found that the incidence of depression increased by 49.86% from 1999 to 2017 (Lui et al., 2020). Furthermore, in the same year (2017), 4,4% of the world's population was diagnosed with a common mental disorder (Pillay, 2019). During the same period, it was estimated that 4,6 % of South Africa's population had either a mood or anxiety condition (Pillay, 2019). Thus, common mental disorders are a growing health concern within the South African context, with one in every six South Africans diagnosed with a common mental disorder within their lifetime (Pillay, 2019). Of the 4,6% of the South African population diagnosed with a common mental disorder, 30.3% have mood and anxiety disorders, while 43.7% suffer from either substance use disorder or other mental conditions (Pillay, 2019). More recent statistics found by the national survey by the Wits/Medical Research Council Developmental Pathways for Health Research Unit indicated that amongst the South African population, an estimated 25.7% and 17% suffer from mood and anxiety-related disorders(African Population and Health Research Center, 2022).

This is consistent with earlier research by Herman et al. (2009), who reported that the mental health conditions most often diagnosed within the South African context are common mental disorders and that anxiety, depression, bipolar and substance use disorders were the most prevalent.

While the term common mental disorders includes a broad range of health conditions such as depression, bipolar mood disorder, anxiety, post-traumatic stress disorder, as well as substance use disorders, these disorders have symptoms, which, if severe enough, negatively influence a person's ability to engage independently in their various life roles and occupations (American Occupational Therapy Association, 2020; American Psychiatric Association, 2022). In particular, one of these occupational

domains influenced by common mental disorders is work (World Health Organization, 2022).

Common mental disorders particularly impact work negatively by reducing the employee's mental well-being and productivity, as well as being associated with higher absenteeism from work (Bubonya et al., 2017). These conditions are also linked to reduced cognition, social engagement, personal identity, coping capacity, and emotional regulation (World Health Organization, 2022).

Cognitive deficits are impairments within the domain of cognition, which includes the cognitive process of combining intellectual functions such as attention, memory, visual skills, language, and executive functioning (Dhakal et al., 2023). Cognitive deficits are a core feature of common mental disorders (American Occupational Therapy Association, 2020). Atique-Ur-Rehman et al. (2019) confirmed that cognitive deficits associated with depression are functionally impairing and have a disabling effect on a person diagnosed with a common mental disorder. Over 95% of individuals diagnosed with major depressive disorder experience cognitive deficits (Atique-Ur-Rehman et al., 2019). Conversely, Seeberg et al. (2016) reported a lower figure of between 50-70% of people diagnosed with a mood disorder as experiencing cognitive deficits. Research has indicated that these cognitive deficits remain even if the person diagnosed with common mental disorders' mood becomes euthymic due to pharmacotherapy (Atique-Ur-Rehman et al., 2019). These cognitive deficits have been reported to directly impact work performance and productivity, leading to high absenteeism from work (Atique-Ur-Rehman et al., 2019).

In South Africa, reduced work performance due to symptoms resulting from low mood, high anxiety, low volition, and cognitive deficits is associated with the need for temporary incapacity leave from work, with the option to extend this to permanent incapacity leave if the symptoms do not dissipate (Government of South Africa, 2021; van Niekerk et al., 2020).

However, research has also reported that an early return to work and a supportive work environment positively promote psychological and cognitive well-being and recovery from a common mental health disorder (Kielhofner, 2008; South African

Society of Psychiatrists, 2020). Work provides a person diagnosed with a common mental disorder with a sense of purpose, identity, achievement and social belonging, all factors which are negatively impacted by common mental disorders (Blank et al., 2015; Kielhofner, 2008; South African Society of Psychiatrists, 2020). In contrast, it has been reported that incapacity leave extending past six months has been statistically linked to a poor vocational prognosis and may lead to psychosocial disability (van Niekerk et al., 2020). Severe psychological symptoms and cognitive deficits influence the individual's ability to engage in daily tasks and function at a societal level (van Niekerk et al., 2020). These symptoms may lead to functional impairments or psychosocial disability (temporary disability caused by a psychological illness) (van Niekerk et al., 2020). Impairments are addressed in therapy by the mental healthcare user's treating team of service providers, who should carefully consider the judicious advantages and disadvantages of incapacity leave to the long-term mental health of the person diagnosed with a common mental disorder.

1.2 Problem statement

The researcher, from her clinical experience, found anecdotal evidence that the extended temporary incapacity leave process often negatively impacts the recovery of the person diagnosed with common mental disorders. The researcher has been employed as an occupational therapist in private practice for more than 6 years. Persons diagnosed with common mental disorders are referred for occupational therapy assessments to determine if their psychological symptoms, inclusive of anxiety, depression, and cognitive decline, impact their ability to productively engage within the occupational area of work. If the assessment findings indicate that the client's symptoms cause them to experience a temporary psychosocial disability, a period of temporary incapacity leave is recommended by the occupational therapist (van Niekerk et al., 2020).

Work is reported to be beneficial in promoting and maintaining mental well-being and by being extracted from work the person diagnosed with a common mental disorder may be more susceptible to the adverse effects of a lack of meaningful engagement within the area of work (Mardon et al., 2021; Sandoghdar et al., 2023; Waller, 2020).

Some research suggests that during this period of work extraction, the person diagnosed with a common mental disorder may fail to benefit from the anticipated positive gains of promoting recovery and regaining psychological well-being by perpetuating mood and anxiety symptoms as well as cognitive deficits (World Health Organization, 2022; South African Society of Psychiatrists, 2020). On the other hand, early return to work has been found to promote psychological, emotional, and cognitive health. Additionally, work is thought to promote recovery if the work environment is supportive and reduces the risk of permanent disability (South African Society of Psychiatrists, 2020). A lack of occupational identity which is a consequence of extended incapacity leave, leads to the individual's sense of inner destabilisation, limited sense of life meaning, social engagement, and ultimately decreased volition because the person does not receive positive feedback from the environment regarding personal and life tasks mastered (Blank et al., 2015; Kielhofner, 2008). Furthermore, the financial benefits received from the insurer may provide the person diagnosed with a common mental disorder with extrinsic motivation, such as financial gain, to remain on incapacity leave, reducing vocational volition (Timp et al., 2024). Therefore, it can be concluded that the lack of meaningful and purposeful engagement within the occupation of work may perpetuate psychological symptomology and cause cognitive deterioration, as well as intensification of mood and anxiety symptoms, increasing the proclivity of permanent disability occurring (South African Society of Psychiatrists, 2020).

Understanding the relationship between temporary incapacity leave and psychological symptoms, such as cognition, may benefit occupational therapists in recommending work extraction periods that are therapeutic and provide a person diagnosed with a common mental disorder with an optimal recovery period. This would be more beneficial than recommending lengthy incapacity leave, causing further cognitive decline and intensification of mood and anxiety symptoms, which may cause a permanent psychosocial disability. Furthermore, understanding this relationship may aid in determining risk factors (changes in client factors) that increase the development of permanent psychosocial disability.

1.3 Purpose of the study

The purpose of this study was to explore the effect of temporary incapacity leave on mental functions in a person diagnosed with a common mental disorder. The researcher is employed by a private occupational therapy practice, and within the context, the client records were compiled by the various therapists employed at the practice. The role of an occupational therapist is to establish compatibility regarding client functioning and the demands of engagement within the various occupational areas. Work is one of the main occupational areas amongst the adult population. A person diagnosed with a common mental disorder may experience severe symptoms resulting in a temporary psychosocial disability. During these periods, it is the occupational therapist's role to assist these persons to mitigate, manage and ultimately retain independent functioning at home and within the workplace. To achieve the latter, the occupational therapist needs to understand the impact common mental disorders have on the client's ability to independently and productively engage within their work environment. Additionally, due to the severity of the psychosocial disability, the person diagnosed with a common mental disorder may need to be extracted from their work environments to allow for pharmacotherapy adjustments and rehabilitative services (vocational rehabilitation- specialized occupational therapy intervention focused on preparing a person physically, emotionally as well as cognitively for return to work). If the abovementioned is needed, then the person diagnosed with a common mental disorder may require sick leave (maximum of two weeks) or temporary incapacity leave (one month or more) to allow for the abovementioned interventions to occur. The occupational therapist, in collaboration with the person's psychiatrist, recommends which leave period needed. The purpose of this study is to gain a better understanding of the relational effect between temporary incapacity leave and mental functions to allow the therapist to make therapeutic recommendations regarding the optimal time for return to work.

1.4 Research question

What are the effects of temporary incapacity leave (3-24 months) on specific mental functions among persons diagnosed with common mental disorders?

1.5 Research aim.

This research aimed to explore the effects of temporary incapacity leave (3-24 months) on specific mental functions among those persons diagnosed with common mental disorders, based on a retrospective record review, as well as the severity of symptoms that influenced return or non-return to work in the Eastern Cape, South Africa.

1.6 Research Objectives.

Four research objectives guided this study in answering the research question above.

- Determine the effect temporary incapacity leave (3 to 24 months) has on cognitive functions such as memory, attention, visual-spatial skills, and language of a person diagnosed with a common mental disorder in the Eastern Cape over time.
- To determine the effect of temporary incapacity leave (3 to 24 months) on the intensity of mood and anxiety-related symptoms among persons diagnosed with common mental disorders in the Eastern Cape over time.
- To determine the effect of changes in mood and cognition on receipt of temporary or permanent incapacity leave in a person diagnosed with a common mental disorder in the Eastern Cape.
- To determine the effect of change in mood and cognition in terms of return to work in a person diagnosed with common mental disorders in the Eastern Cape.

1.7 Justification of the study.

This retrospective study utilised the records of occupational therapy assessments to examine the impact of temporary incapacity leave (3-24 months) on a person diagnosed with a common mental disorder's experience of changes in psychological symptoms (anxiety and depression) as well as cognition to determine the most judicious time to recommend return to work or extension of incapacity leave. The first or baseline assessment was performed at 0 months; the first review assessment was conducted between 6 and 12 months on the recommendation of the insurance

company's case manager. These assessments focused on identifying impairments that may lead to psychosocial disability and monitoring the progression of the illness. Impairments, which are screened during the assessment process, were the intensity of psychological symptoms (mood and anxiety symptoms, as well as emotional dysregulation, inherent resilience, motivation, and exposure to stress).

Limited research has been conducted that is focused explicitly on understanding the relational effect between changes in mental functions and the period of work absence.

Understanding the interaction between these factors could greatly assist assessing therapists in recommending therapeutic periods of incapacity leave. Thus, cautiously granting a period of vocational extraction to promote functioning by limiting the adverse effects of prolonged incapacity leave. Findings of this study may assist in the development of policies focused on the strict monitoring of the individual functioning during the incapacity leave period to prevent permanent psychosocial disability from occurring.

1.8 Dissertation outline

This dissertation consists of six chapters, which are organised as follows:

Chapter 1: An introduction to the study. This chapter discusses the study background, problem statement, research question, aims, objectives, and justification.

Chapter 2: Literature review. This chapter consists of an in-depth critical review of the recent literature on the topic, the research variables and their measurement, and the potential role they play in the return to work of persons diagnosed with common mental disorders receiving insurance benefits who live in the Eastern Cape of South Africa.

Chapter 3: Methodology is a detailed description of the research design, process, data collection and ethical procedures followed to complete this study and analysis of the collected data.

Chapter 4: Results. This chapter reports the outcome of the analysis of the collected data. The results are reported using tables and graphs according to the research objectives.

Chapter 5: Discussion. This chapter describes the study's results in relation to the available literature on the subject, highlighting where the literature supports the results and where the results differ from other studies. The discussion will also use the results to answer the research question and objectives.

Chapter 6: Conclusion and recommendations. This chapter concludes the study by summarising the main results, describing their implications for current occupational therapy practice, limitations of the study and recommending future research topics to be explored.

CHAPTER 2: LITERATURE REVIEW

2.1 Introduction

Work is a central occupation of an adult's life and provides the individual with a sense of belonging, identity, economic stability, meaning and purpose. Furthermore, work can be a facilitating factor or a barrier towards mental well-being. Mental well-being can impact motivation as well as productivity within the workplace. Intrinsic and extrinsic personal and/ or work factors may tarnish the employee's mental well-being, resulting in a higher experience of stress, burnout and ultimately the development of a common mental disorder (Mardon et al., 2021; Sandoghdar et al., 2023; Waller, 2020).

Common mental disorders are a grouping of anxiety, depression, post-traumatic stress disorder, and substance use disorder (Meyer et al., 2019). The most reliable and comprehensive study to date regarding the prevalence of common mental disorders within the South African population was derived from the South African Stress and Health study conducted in 2009 indicating that the lifetime prevalence of common mental disorders is 4.9% of major depression, 4.8% have major depression with agoraphobia without panic disorder, 4.5% have alcohol-use disorder, 0.8% panic disorder and 1.4% have a general anxiety disorder (van Wijk, 2021; Herman et al., 2009). More recent global statistics, however, indicate a 12.5% prevalence of common health disorders worldwide; of this population, 81% constitutes adults (World Health Organization, 2022).

Common mental disorders impact the worker's productivity by reducing the employee's motivation to engage in work tasks and causing cognitive deficits (Sandoghdar et al., 2023; Fishbach et al., 2022; Gunnarssen, 2021). Avolition and cognitive decline reduce the employee's ability to maintain a productive work pace (Sandoghdar et al., 2023). Furthermore, persons diagnosed with a common mental disorder have a higher tendency to utilise all their sick leave (in‘t Hout et al., 2024). Depleted sick leave, as well as temporary psychosocial disability caused by symptoms during the acute or relapse phase of these disorders, may require temporary incapacity leave. Temporary incapacity leave is a leave type that can come into effect

if the individual is temporarily disabled by symptoms of a physical or mental condition (Talatalai et al., 2020).

Prolonged incapacity leave, however, may prevent the person diagnosed with a common mental disorder from benefiting from the positive aspects of work, such as experiencing a sense of belonging or community, healthy work identity, economic stability, and self-efficacy (Sandoghdar et al., 2023).

This literature review comprised the main concepts reflected in the research topic, problem statement aims and objectives of the study. The researcher used the University of Witwatersrand's online library as the search source to retrieve research articles, books and relevant sources used in the literature review. Interdisciplinary sources were gauged when seeming relevant to a central argument. The following concepts, in various orders (Boolean phrases) for the search, were mostly used: occupational therapy, work, common mental health disorders, depression, anxiety, cognition, work; return to work, functional capacity evaluations; unemployment; and incapacity leave.

The literature review is structured as follows. The employment industry within the South African context was discussed first. Thereafter, the occupational therapist's role is in treating persons diagnosed with common mental disorders within the occupational area of work using the occupational therapy process. The occupational therapy process consists of three phases, each phase of equal importance. However, this study is mainly situated within the first phase of the occupational therapy process. The Occupational Performance Model (Australia) guides the occupational therapist's clinical judgment throughout the entire occupational therapy process. The Occupational Performance Model (Australia) focuses on the interrelationship between the person and the environment, and within the context of common mental disorders, it focuses on the interrelationship between the person (client factors in particular specific mental functions) and the environment work.

2.2 Employment prospects within the South African context

In 2021, South Africa was rated as one of the countries with the highest unemployment rate of 34.4%, consisting of people within the population seeking employment (this percentage does not include the unemployed individuals not actively seeking employment). The South African quarterly financial report indicated a slight improvement in the unemployment rate of 32.1% in 2023 (National Economic Development and Labour Council, 2024). Despite this slight increase, South Africa's high unemployment rate remains a significant contributing factor towards poverty within the country. The age group most affected by unemployment are the youth between 15 and 35 years old due to poor structural development and job creation (Matyana et al., 2023). Unemployment remains a significant problem in South Africa, contributing to economic instability and limiting economic growth (Khalid, 2021).

South Africans employed within the open labour market in both the government and the private sector rely on disability cover to provide them with financial support if injury or illness causes temporary or permanent disability. (Association for Savings & Investment SA, 2021). Disability is viewed as the "alteration of the capability to meet the personal, social, or occupational demands due to an impairment, and is not assessed merely clinically" (Mokoka et al., 2017, p.36). Whereas impairments are changes to normal physiological or anatomical functioning due to an illness or injury (Mokoka et al., 2017).

Several conditions, such as neurological, immunological, and muscular conditions, may lead to temporary or permanent disability (Carpenter et al., 2022). The World Health Organization estimated that over 1.3 million people worldwide have a disability (World Health Organization, 2023). The highest percentage of the South African population receiving disability benefits in 2017 was 13.8% due to mental disorders (Carpenter et al., 2022).

2.3 Disability benefits/ income protection policy for temporary and permanent incapacity leave and the occupational therapist's role during the incapacity process.

Disability cover provides the policy beneficiary with 75% of their salary for the duration of the incapacity period. Acute non-permanent conditions warrant temporary incapacity leave, with a viable option if more than three months are needed due to ill health (Department of Labour, 1998; Old Mutual, 2023). Temporary incapacity leave is a unique leave granted to individuals who, due to a medical or psychological condition, cannot meet their work demands. According to the South African Labour Relations Act 66 (1995), the employee must first utilise all available sick leave in the current leave cycle before applying for temporary incapacity leave. Incapacity leave is subdivided into two components: temporary and permanent. Temporary incapacity leave is applicable if symptoms related to the illness or disorder are temporary (temporarily disabling). Permanent incapacity leave is granted if the disability is permanent, and recovery is not possible (Government of South Africa, 2021).

The employee needs to apply for incapacity leave through their employer. To apply, the employee needs to gather supporting documentation confirming that they are experiencing temporary psychosocial disability warranting the need for incapacity leave from their multidisciplinary team (psychiatrist and occupational therapist) (Department: Public Services and Administration, Republic of South Africa, n.d.; National Economic Development and Labour Council, 2024). The occupational therapist plays a unique role during this process as they are experts in establishing symptoms' functional implications (American Occupational Therapy Association, 2021). The occupational therapist uses their expertise to determine if the client's symptoms or illness experience prevents or restricts them from engaging in their daily occupations. An occupational therapy evaluation (as explained under the evaluation phase of the occupational therapy process) is used to determine independent engagement within the occupation of work. If the evaluation's outcome indicates that the person diagnosed with a common mental disorder is unable to independently engage within their work environment, then the occupational therapist will make a

recommendation for temporary incapacity leave (National Economic Development and Labour Council, 2024).

Temporary incapacity leave must be approved by the client's employer and the insurance company with which the employer has a preexisting policy. The leave may be changed to permanent incapacity leave if the client fails to achieve psychological homeostasis or regain the functional capacity to return to their nominated occupation or seek alternative employment within the open labour market. In the case of permanent incapacity leave, the client receives 75% of their salary until retirement age or receives a once-off payment (Ramano et al., 2018; Old Mutual, 2023).

The insurance house (such as Old Mutual, Sanlam, Capital Alliance, Discovery, Alexander Forbes and Hollard) assigns the client (a claimant) a case manager. If needed, the case manager assigns the claimant a treating occupational therapist to initiate a work hardening programme (treatment focused on preparing the claimant physically, emotionally, cognitively, and psychologically for work reintegration) or rehabilitation (restoring specific mental functions). Treatment is either funded by the insurance company or self-funded by the claimant. If occupational therapy services were recommended in the baseline assessment, the insurance company may request a treatment progress report every six months or any needed further assessments (Old Mutual, 2023).

2.4 The occupational therapist's scope in the mental health field.

Mental health is a growing concern within the South African population. Occupational therapists play a vital role in the management of mental conditions by promoting independence in occupations. The section below will focus on the role of an occupational therapist within the field of mental health.

> *"Occupational therapy is a client-centred health profession that promotes health and well-being through engagement in occupation. The primary goal of occupational therapy is to enable people to participate in everyday life activities. Occupational therapists achieve this outcome by working with people and communities to enhance their*

> *ability to engage in chosen occupations, need to, or are expected to do, or by modifying the occupation or the environment to better support their occupational engagement"* (World Federation of Occupational Therapists, 2012, p.4).

The focus of occupational therapy is to encourage active engagement within daily activities and life roles (Ranka et al., 2011). Occupational therapy outcomes are achieved through rehabilitative services (retraining a specific skill or ability) or modifying occupations, meaning changing the manner or environment in which a task is done (World Federation of Occupational Therapists, 2012). Occupational therapy services also focus on the promotion of health and independence for clients who present with temporary, permanent or no disabilities.

Occupational therapy services are rendered within the public and private sectors and occur within hospitals, rehabilitative centres, client homes and workplaces (World Federation of Occupational Therapists, 2012). Occupational therapists are trained and work within various fields, namely mental health, physical and neurology, hands and upper limb, driving and community mobility, practice management, geriatrics, pain management, sensory integration, paediatrics general, low vision, vocational rehabilitation, medical-legal, academics and palliative care. Occupational therapists work with a variety of clients of all ages, ranging from infancy to geriatrics (American Occupational Therapy Association, 2020). Services are rendered to a broad spectrum of conditions, inclusive of and not limited to physical, psychological, and developmental conditions (American Occupational Therapy Association, 2020).

The focus of occupational therapy services is to enhance or acquire, as well as prevent the loss of, occupational identity. Occupational identity is theorized as the belief that the individual's sense of self is based on engagements within occupations (Hansson et al., 2022). Occupational identity has been linked to emotional experiences and holds the premise that if an occupational identity is well-established, emotions are based on the characteristics of the experience (Maloney, 2022). Restriction in occupational identity and a loss thereof may be a result of a medical condition and/ or psychological disorder. Medical conditions that may lead to functional impairments or disability are

musculoskeletal conditions (anatomical abnormalities of bones, tendons and muscles caused by injury or genetics), neurological conditions (brain injury trauma or injury), cardiac conditions, cancer, and mental disorders (Gan, 2014). Symptoms associated with medical or psychological conditions or disorders can lead to a reduction in activity participation (American Occupational Therapy Association, 2020). The Occupational Performance Model (Australia) is one theoretical framework used to understand the relationship between the person-context and performance of daily activities and how common mental disorders lead to changes in activity participation (Ranka et al., 2011).

2.5 Theoretical Model

Occupational therapists employed by the private practice where the research was done, and who conducted the client assessments and compiled the reports reflected in the client records used for this study utilize the Occupational Performance Model (Australia) (Chapparo & Ranka,1997) as the theoretical model that guided their clinical judgement and because it is viewed best suited in supporting contextual clinical reasoning. Mental health and well-being consist of an interplay of various intrinsic (client factors- specific and global mental functions, attitude, and stress) and extrinsic factors (environmental factors- personal and work-related environments). The Occupational Performance Model (Australia) is a widely used model amongst occupational therapists within the field of mental health. The model uses a client-centred approach that places the individual and their unique occupational roles, values, and goals at the centre of therapeutic intervention strategies (Chapparo & Ranka,1997). Mental disorders tarnish and significantly impact the individual's ability to derive meaning and purpose from activity engagement, as well as the development and maintenance of identity. The heading that follows gives a detailed explanation of the impact common mental disorders have on the individual's ability to engage in various occupational and life roles.

2.5.1 Occupational Performance Model (Australia) OPM(A)

This model reiterates a central maxim in occupational therapy: people are viewed from a holistic perspective consisting of a body, mind and spirit. Focusing on the lifelong relationship between the person and context (environment) (Ranka et al., 2011). Actively engaging in various occupations provides the individual with autonomy, a

sense of reality, mastery, competence and temporal organization. Occupational engagement consists of the individual interacting with the environment. This theoretical model holds the viewpoint that health is not the absence of disease or illness but the ability to continue engaging in occupational tasks despite illness or disease (Chapparo et al., 1997). The individual actively participated in creating an occupational identity, including a core identity as a productive worker. The development of this occupational identity is intrinsically (values, needs and desires) or extrinsically motivated (environmental factors) (Chapparo et al., 1997). Occupational being or identity is self-expression through occupational performance or occupational roles (Chapparo et al., 1997).

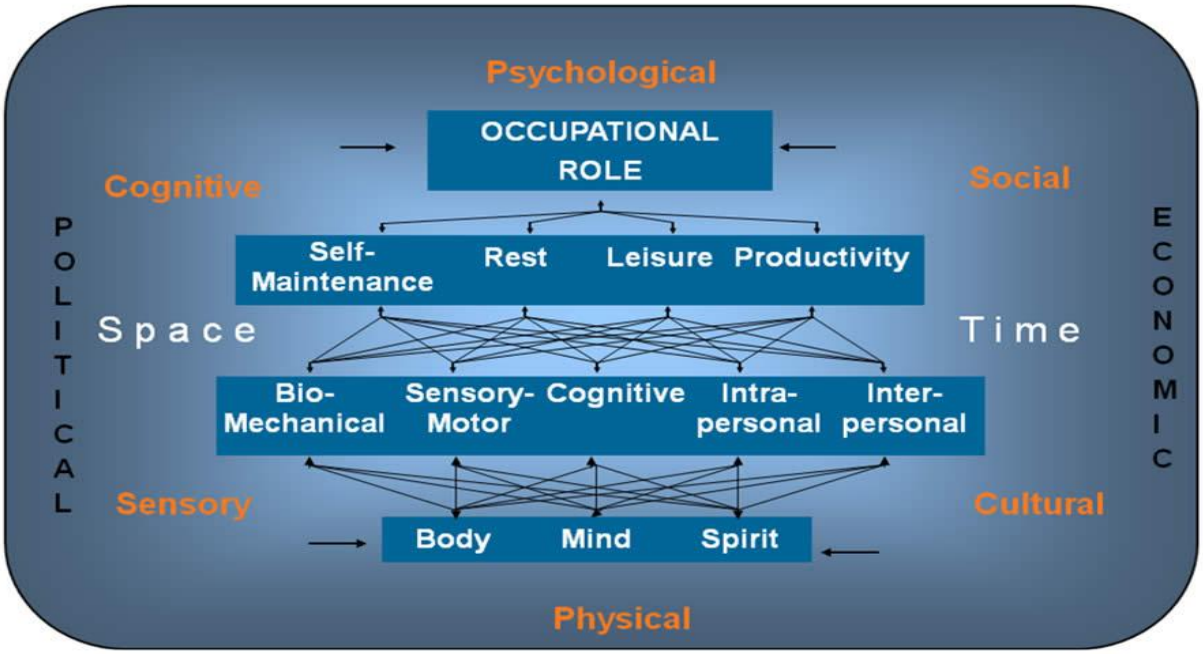


Figure 2.1. Illustration of the Occupational Performance Model (Australia) (Ranka et al., 2011, permission for use of the image is in Appendix A)

Figure 2.1. consists of an illustration explaining the different constructs and structural levels of the Occupational Performance Model (Australia) (Ranka et al., 2011; Chapparo & Ranka,1997). The environment (work) is viewed as either a facilitating factor or a barrier towards mental well-being. The environment and the person (client

factors as listed under the third level of the occupational performance model (Australia), biomechanical, sensory-motor, cognitive, as well as intra- and interpersonal factors) have a cause-and-effect relationship. Factors within both components, the environment and inherent/ intrinsic client factors, either facilitate or hinder occupational performance. For example, if the person's cognition, motivation and inherent abilities are compatible with their work demands and the work environment is supportive, it will allow the individual the opportunity to self-actualise and maintain their mental well-being. Alternatively, if the client's work environment is unsupportive, exposing them to significant levels of stress leads to a decline in mental well-being. Reduced mental well-being caused by either personal or work-related stress changes in client factors. Vice versa, changes in the environment can lead to changes within the client factors. Both alter occupational performance. Within the context of common mental disorders, symptoms associated with these conditions impact the individual on the third level (biomechanical, sensory-motor, cognitive, as well as intra- and interpersonal factors). Changes occur in body functions, which in turn impact other levels of the model. For example, anxiety and depression have been linked with sensory processing difficulties, impacting the level of sensory-motor functions (Costa-López et al., 2021). Sensory changes may lead to changes in the manner the individual engages with the environment, leading to performance changes.

2.5.1.1. Occupational Performance

Performance is viewed as the movement precipitated by sequential motor planning, cognition, sensory integration and input, mental processes, and emotional processes needed to perform a specific task (Ranka et al., 2011). The mental processes needed for task execution or performance are also known as executive functioning. Executive functioning consists of cognitive abilities (such as immediate memory and attention), inhibition and interference control, and mental flexibility (Cristofori et al., 2019). Task performance relies on a combined use of cognitive skills, inhibition control and mental flexibility; a disruption in one of these abilities may restrict or limit task execution (Cheng et al., 2017; Hirsch et al., 2018).

Common mental disorders negatively impact each of these aspects (cognition, inhibition control, and mental flexibility), which directly impacts task performance (Cheng et al., 2017; Cristofori et al., 2019; Hirsch et al., 2018). Inhibition control is restricted by emotional dysregulation, predisposing the person diagnosed with a common mental disorder towards impulsive behaviour driven by their emotional experience (Marques et al., 2024). The individual may experience irritability, causing aggressive outbursts, crying spells, and/ or panic attacks (build-up of anxiety) (Kendricks, 2020).

Furthermore, continuous exposure to stress hormones associated with anxiety elicits the fight/ flight/ freeze/ fawn sympathetic response (de Souza Duarte et al., 2017). These hormonal changes predispose the person diagnosed with a common mental disorder to physical symptoms such as headache, dizziness, and nausea. Physical symptoms associated with anxiety can be temporarily functionally impairing and restrict task performance as the person feels unwell (de Souza Duarte et al., 2017; Seng, 2018; Ranka et al., 2011).

Each person is instinctively inclined to respond to stressors in one of the following ways. If the person diagnosed with a common mental disorder enters the fight response, they are more prone to irritability, anger outbursts, aggressive behaviour and are more confrontational. A person in the fight response will engage aggressively with their environment, as aggression is the driver for task performance. The fight-or-flight response increases the need to escape or run away from the situation. The flight response increases restless energy in the person diagnosed with a common mental disorder. Restless energy increases task performance; however, tasks are done to avoid discomfort or situations perceived to be stressful. An increase in thought processes causes the person to become internally distracted by thoughts, resulting in a loss of focus (de Souza Duarte et al., 2017; Seng, 2018; Ranka et al., 2011).

The freeze response immobilizes the person diagnosed with a common mental disorder and impacts task performance by restricting decision-making abilities, causing dissociation and procrastination. The freeze response prevents task engagement. The fawn response increases the need for safety through the

prioritization of others' needs over the self. People prone to experiencing the fawn response perform tasks to please others, causing them to have poor boundaries. Each of these stress responses elicited by anxiety and stress impacts task performance differently. It is, however, evident that the stress response changes how the person diagnosed with a common mental disorder engages within their environment as well as performs tasks (de Souza Duarte et al., 2017; Seng, 2018; Ranka et al., 2011).

Task performance is often driven by motivation (either intrinsic or extrinsic). Many intrinsic (internal) and extrinsic (external) factors can drive motivation and are inclusive of but not limited to emotions and volition, self-actualization, and meeting basic needs (food, shelter, etc). Symptoms of common mental disorders, such as avolition (lack of motivation caused by depression), impede intrinsic motivation (internal drive), preventing task performance and causing a higher proclivity to procrastinate when needing to perform basic daily tasks such as hygiene activities, cooking, cleaning, etc. Due to a decline in intrinsic motivation, the person diagnosed with a common mental disorder is no longer motivated to initiate tasks (de Souza Duarte et al., 2017; Ranka et al., 2011). Poorer task initiation is linked to reduced engagement within occupations, which may lead to activity deprivation as the loss of the beneficial aspects associated with occupational performance, such as identity formation and maintenance (Blank et al., 2015).

2.5.1.2 Occupational Roles

Occupational roles consist of socially appropriate sequential behaviour required to perform a specific function within society. Societal roles are subdivided into family, gender, social, cultural and occupational roles. Occupational roles change throughout the individual's lifetime (Chapparo et al., 1997). For example, as a child and adolescent, the individual is a scholar; in adulthood, the role becomes employer or employee (essentially a worker), thereafter a pensioner. Common mental disorders can have short- and/ or long-term effects, such as poorer productive role performance, which refers to decreased productivity or participation in various life roles such as work and social interaction (Kessler et al., 2009; Oliveira et al., 2022). At each stage of life, the individual fulfils different roles, each with its meaning and purpose. The individual

derives great meaning from fulfilling a specific role. These roles also form part of the individual's identity. A lack of life role participation is linked to decreased participation in daily activities and restriction in occupational participation (World Health Organisation, 2001; Ranka et al., 2011). A lack of role performance over a long period substantially reduced the quality of life and a loss of specific life roles (parent, sibling, employee, etc). The long-term effects of the loss of life roles could lead to permanent disability within this population as the individual no longer actively engages on a societal level (Kessler et al., 2009).

2.5.1.3 Occupational Performance Areas.

Occupational performance areas initially consisted of three main areas: self-maintenance, productivity/school and leisure occupation (Chapparo et al., 1997). The Occupational Therapy Practice Framework 4th edition (American Occupational Therapy Association, 2020) divided occupations into nine aspects, inclusive of activities of daily living, instrumental activities of daily living, health management, rest and sleep, education, work, play, leisure and social participation. A study conducted by Gunnarsson et al. (2021) found that depression and anxiety negatively impact independent engagement within self-care, productivity/work, household management, play and school, and leisure participation. The volition/ motivation or drive of an individual diagnosed with a common mental disorder is impacted by anxiety and depression, influencing the frequency and quality of hygiene activities such as bathing, dressing, eating and grooming. A reduction in participating in hygiene performance patterns influences the individual's appearance. Impairments in immediate memory associated with these conditions hinder the individual's ability to remember to engage in hygiene activities (Gunnarsson et al., 2021).

Paid work is one of the main occupational area’s adults engage in and consists of performing various tasks for which the individual is remunerated (Sandoghdar et al., 2023). Symptoms associated with common mental disorders remove or limit the person’s drive and/ or capacity to perform work tasks, leading to a lack of independence within this occupational area. Participants in the Gunnarsson et al. (2021) study indicated that cognitive impairments within immediate memory and

attention, task planning, initiation, execution and completion difficulties are the main contributing factors to unproductivity within the work environment. Common mental disorders cause vocational instability, which increases the possibility of employees being retrenched due to ill health. This, in turn, leads to a high unemployment rate within this population (van Wijk et al., 2021).

It gives the person diagnosed with common mental disorders daily structure, purpose, and interaction (Drake et al., 2020). Daily structure aids in managing avolition by providing the mental healthcare user with extrinsic motivation, compensating for their lack of intrinsic motivation (Fishbach et al., 2022). Completing work tasks elicits a sense of achievement, giving the mental healthcare user purpose. The latter enhances self-efficacy and self-worth, decreasing feelings of hopelessness (Sandoghdar et al., 2023).

2.5.1.4 Occupational area of work

Work refers to engagement in tasks that involve the physical and mental application of human abilities to pursue a goal—in the past, work predominantly consisted of human necessity and survival (Sandoghdar et al., 2023). Work was seen as a medium to ensure that basic needs such as shelter, food and essentials could be obtained (Sandoghdar et al., 2023). The modern-day workforce no longer views work as only a means of acquiring economic resources but rather as a social environment through which great meaning and purpose are derived (Mardon et al., 2021).

Work provides the modern employee with both extrinsic (economic stability, status and a sense of monetary security) and intrinsic meaning (fulfilment, creative expression and a sense of purpose) (Khan, 2020; Sandoghdar et al., 2023). Intrinsic meaning is created through fostering belonging, authenticity, purpose, self-efficacy, and enhancement of the worker's self-esteem. Contrary, a lack of financial security, meaning and purpose within the workplace may lead to a decline in mental well-being (Sandoghdar et al., 2023; Fishbach et al., 2022).

A sense of belonging within the work environment is the ability to establish positive interpersonal relationships with colleagues. Strained or unprofessional interpersonal

relationships within the workplace lead to a lack of belonging, which deprives the employee of meeting one of their fundamental social needs, causing a decline in mental well-being (Waller, 2020). Poor mental well-being is linked to reduced cognitive output, a loss of identity, emotional ramifications, and reduced productivity (Waller, 2020). Cognitive impairments, in particular memory and attention deficits, are a contributing factor towards interpersonal conflict. Attention deficits prevent sustained focus for the duration of the conversation with others, reducing the person's ability to actively listen to the content of the conversation, leading to misunderstandings as well as miscommunication (Mendes, 2024). The cognitive decline also impacts the person diagnosed with a common mental disorder's sense of self/ self-esteem due to embarrassment about their performance in cognitive tasks (Mendes, 2024).

A study on the perspective of supervisors regarding mental illness within the South African workforce found that supervisors often have a misconception surrounding the cause, treatment and impact of the work environment on employees diagnosed with a common mental disorder. The consensus amongst most of these participants was that the South African supervisors lacked formal training in the appropriate management of employees struggling with a common mental disorder and identified a need for reform (De Jesus et al., 2024). A lack of reform in the South African work environment increases the employee's risk of being stigmatised, misunderstood and discriminated against (Crouch et al., 2014). The work environment, if perceived to be supportive by the employee, often increases job satisfaction and a higher employee retention rate (Monteiro et al., 2023; Fishbach et al., 2022). A toxic work culture causes employees to experience high levels of stress, predisposing staff to developing burnout and depression (Monteiro et al., 2023).

The work environment has a significant impact on worker identity (Waller, 2020). The Model of Human Occupation, developed by Kielhofner in 2002 (Kielhofner, 2008), identified motivation as the main driving factor for occupational choices and its impact on occupational engagement. Occupations are often selected based on commonality with personal traits. When the work environment, demands and tasks are in line with the employee's identity and characteristic traits, it nurtures authenticity (Sandoghdar et al., 2023). A lack of authenticity or incompatibility of the work environment, values

of the company and colleagues could lead to a loss of a worker's identity (Sandoghdar et al., 2023). Furthermore, to establish a healthy work identity, the employee needs to feel valued and appreciated, leading to a sense of accomplishment (Sandoghdar et al., 2023). A lack of worker identity may negatively impact the employee's overall occupational identity and, in combination with an unconducive work environment, may lead to a decline in mental well-being (Khalid et al., 2024). The person-environment fit is crucial for the maintenance of mental well-being within the workplace. If the employee's inherent capacity (cognition, personality profile and temperament) is incompatible with the working environment or work demand, it may lead to chronic fatigue, unproductivity and a higher experience of work stress, predisposing the employee to burnout and poor mental well-being (Meyer et al.,2018). The restoration of client factors through engagement in occupational therapy services (vocational rehabilitation) forms a singular part of the complex interaction between the person and the environment. The work environment is considered an independent variable within this relationship and a driving force influencing the return-to-work prognosis.

Mental well-being is the ability to successfully manage and cope with life stressors while remaining productive (Sandoghdar et al., 2023). When the work environment promotes mental wellness among employees, it increases intrinsic work motivation and productivity (Sandoghdar et al., 2023; Fishbach et al., 2022). Reduced mental well-being has a detrimental effect on the employee and his/her family, in addition to economic losses (Knapp et al., 2020; Rodriguez et al., 2022). The employer experiences financial loss as a result of the employees suffering from a common mental disorder due to high absenteeism from work as well as unproductivity during working hours. The employee may also experience financial loss due to the depletion of sick and annual leave caused by high absenteeism, resulting in unpaid leave (van Wijk et al., 2021).

An inability to cope with stress tarnishes the employee’s mental well-being, causing a decline in motivation and productivity, which could lead to burnout. Burnout may predispose or perpetuate the employee to several physical and psychological conditions, particularly cardiovascular abnormalities as well as mental disorders (Anadkar et al., 2023). Burnout is a result of the employee feeling out of control within

the workplace (Kapur, 2021). A lack of control also reduces self-efficacy, which is a mechanism for maintaining mental well-being within the workplace (Sandoghdar et al., 2023). Factors such as (authoritative and unsupportive) management styles, inconsistency in work procedures and treatment of staff, a lack of promotional opportunities and/ or salary increase, a lack of skill enhancement or training opportunities, a lack of problem-focused handling of work challenges, as well as a lack of emotional support increases the employees predisposition towards developing burnout symptoms (Kapur, 2021; Anadkar et al., 2023). Furthermore, burnout is due to a high workload impacting the employee's ability to maintain a healthy work- life balance (Anadkar et al., 2023). Scanlan et al. (2019) found that efforts to increase the meaningfulness of work activities and allow staff to actively enjoy work tasks may greatly aid in preventing burnout from occurring.

As indicated by Sandoghdar et al. (2023), a lack of self-efficacy within the work environment prevents the employee from establishing a sense of belonging and a healthy work identity, impacting the employee's overall mental well-being and leading to the development of common mental disorders (Anadkar et al., 2023).

2.5.1.5 Space and Time

The relationship between the person-environment-performance is a crucial part of this model. The theory considers two environments that interact through continuous dialogue occurring within space and time. The internal environment “is composed of the aggregate structures, conditions and influences about the occupational performance that are found within humans” (Chapparo et al.1997, p. 3). The external environment consists of sensory stimuli and physical, social and cultural aspects. (Chapparo et al., p. 3, 1997).

The internal work environment consists of client factors needed to perform work tasks that form part of the individual job description. These client factors may vary from occupation to occupation. The main client factors are divided into the following categories: physical ability, cognitive capacity, sensory stimuli and emotional components. Each occupation (job) requires different skill levels under each of the categories. For example, a construction worker will be required to lift heavy objects

and perform more labour-intensive tasks during the working day. Whereas an administrative clerk's physical demand consists of sitting, typing and lifting light objects. Each occupation will require a specific set of client factors for the work tasks to be completed successfully.

The person, environment and occupation are intertwined, and changes within one area directly impact upon the other aspects. These changes could promote functioning or dysfunction (Ranka, 2025). The affective, cognitive and behavioural changes caused by the symptoms of common mental disorders result in changes in the manner a person engages with the environment and thus participates in occupations (Polatajko et al., 2007; American Psychiatric Association, 2022). The symptoms experienced by the mental healthcare user cause structural changes within the person, such as chemical changes in the neurotransmitter system, as well as hormonal changes that occur in the case of anxiety. Functional changes within thought patterns, emotional experience, psychomotor movement, cognitive processing abilities and cognition also occur (American Psychiatric Association, 2022; World Health Organisation, 2001).

These functional physical and cognitive changes result in the person interacting or behaving differently within a preexisting environment. Ultimately changing the individual's engagement within occupations (Ranka et al., 2011). People diagnosed with a common mental disorder due to engagement changes in their work environment may need a period of vocational extraction (sick leave or temporary incapacity leave) to allow for the exploration of various treatment avenues (pharmacotherapy, psychotherapy, and occupational therapy) and time to recuperate. One of the treatment avenues required to promote productive engagement within the work environment is occupational therapy (American Psychiatric Association, 2022; Boland et al., 2024; Crouch et al., 2014).

2.6. The Occupational Therapy Process

Akin to most health professions, occupational therapists utilise a predetermined approach referred to as the occupational therapy process, consisting of three phases: evaluation, intervention and outcome (American Psychiatric Association, 2022). The

occupational therapy process is used within all contexts and the assessment and treatment of all clients (individuals treated by occupational therapists) (American Occupational Therapy Association, 2020). The occupational therapist employed within the practice where the study was conducted and records used to collect the data use the occupational therapy process as the intervention structure. This study is situated within the evaluation phase of the occupational therapy process, focusing on the client factors which may prevent engagement within occupational areas, as well as determining the need for incapacity leave.

The occupational therapy process is divided into the following sequential steps:

Phase One – Evaluation: The main purpose of the evaluation process is to determine occupational barriers and the cause thereof. During this phase, the occupational therapist selects appropriate standardised assessment tools to obtain objective assessment data regarding client factors. Additionally, subjective information is obtained via self-report questionnaires and interviews conducted with the client, their family members, employers or any relevant stakeholders if applicable to the specific case. The occupational therapist within the private practice where the study was conducted considers both subjective and objective data when drawing clinical judgements about the client's vocational prognosis (return to work prospects). The field of vocational rehabilitation in mental health will be the primary area of focus for this research study (American Occupational Therapy Association, 2020).

Phase Two **- Intervention**: During this phase of the process, a treatment plan is developed and implemented using either individual or group therapy sessions. The intervention plan is reviewed throughout the treatment process to determine the effectiveness of the intervention as well as to identify the need for adaptation to the initial intervention plan if needed (American Occupational Therapy Association, 2020).

Phase Three **– Outcomes**: An outcome measurement is selected during the evaluation phase and utilized throughout the treatment process to determine if the treatment goals or outcomes have been achieved. The outcome measure should be valid, reliable as well as be sensitive to changes within occupational engagement and

performance. The outcome measure is also utilized to determine the need for adjusted treatment goals or approaches (American Occupational Therapy Association, 2020).

2.6.1. Phase 1 Evaluation and generation of client records

A person diagnosed with a common mental disorder is usually referred to an occupational therapist's practice. The referral source varies; however, most often, the clients are referred either by their psychologist or psychiatrist. Additional referral sources could be the employer or insurer. As per the first phase (evaluation) of the occupational therapy process, the practice uses standardised assessments and self-report questionnaires in addition to subjective information obtained via the interview process. Below is a description of the standardised assessments as well as self-report questionnaires reflected within the client record of a specific practice in Ggeberha.

2.6.1.1 Standardised Assessments

The standardised assessment used to measure cognition (attention, immediate memory, visuo-spatial skills, and delayed memory) by the occupational therapists employed within the research context is the Repeatable Battery for the Assessment of Neuropsychological Status (RBANS).

The Repeatable Battery for Assessing Neuropsychological Status was developed for the dual purpose of detecting abnormal cognitive decline amongst the elderly, indicative of a dementing process, as well as a screening battery for neuropsychological decline in younger adults. The test battery administration time is 30 minutes and consists of two subtests assessing each of the five cognitive domains. The five domains are immediate memory are visuo-spatial/ constructional abilities, language, attention and delayed memory. A combined score of each cognitive domain is used to determine the overall functional score (Pearson Assessments, 2025).

The immediate memory subtest consists of the initial encoding of information and learning complex and simple verbal information. The Visio-spatial constructional subtest measures basic depth perception and the ability to copy a figure. The attention subtest measures simple auditory registration and recall, visual scanning, as well as

auditory and visual processing speed. The language subtest assesses expressive language. Lastly, the delayed memory subscale screens for deficits in visual and auditory delayed recall and or recognition difficulties (Pearson Assessments, 2025). Raw scores obtained from the abovementioned subscales are converted into standardised scores, which are compared to age-related norms. Normative data ranges from 12- 90 and is divided into intervals of 10.

Common mental disorders cause cognitive deficits within the domains of attention, immediate memory, and executive functioning. These deficits impact work performance and lead to reduced productivity within the workplace (Gunnarsson et al., 2021). The Repeatable Battery for the Assessment of Neuropsychological Status is a valid screening tool to identify and monitor cognitive functions which may pose vocational barriers to identifying the need for occupational therapy intervention.

2.6.1.2 Self-report questionnaires

Self-report questionnaires are used to gain subjective client information to measure the perception of illness and symptoms experienced at the time of the assessment. The scales used in the records are additional information obtained outside the assessment to get a better understanding of the person diagnosed with a common mental disorder's subjective experiences of symptoms and utilise a Likert scale. Common mental disorders are chronic conditions, and as a result, the person diagnosed with the condition's symptoms may experience continuous or only fluctuating in intensity. These questionnaires are used for screening purposes and in conjunction with standardised assessments, interviews and the occupational therapist's objective clinical judgement based on clinical reasoning. The self-reported questionnaires reflected in the records were the Zung Anxiety and Depression Scale as well as the Hospital Anxiety and Depression Scale.

The Zung Anxiety and Depression Scale was developed in 1965 by Dr. William Zung and is based on the diagnostic criteria of the DSM-II. The Zung Anxiety and Depression Scale is a self-administered measure to screen for anxiety and depression symptoms. The Zung anxiety and depression self-report scale is subdivided into an anxiety and depression questionnaire. Each subscale has 20 questions screening for

anxiety and depression. The Zung Self-Report Anxiety and depression scale, despite being developed more than 50 years ago, remains a valid screening tool for anxiety and depression symptoms when compared to its counterparts, such as the Depression Anxiety Stress Scale (Dunstan et al., 2017). Inconsistency in cut-off scores should be taken into consideration when using the Zung Self-Report Depression Scale. A study conducted by Dunstan et al. (2017) recommended that the cut-off score be 50. Dunstan et al. (2020) further conducted studies on the relevance of the Zung Self-Rating Anxiety Scale and found that this scale is a valid tool for screening anxiety symptoms. However, as per their previous findings concerning the Zung Self-Report Depression Scale, the sensitivity of cut-off scores within the clinical setting was found to be consistent with the current cut-off scores. Dunstan et al. (2020) postulate that for research purposes, the cut-off score should be changed to 40.

The Hospital Anxiety and Depression self-report scale was developed by Zigmond and Snaith in 1983 to screen for mood and anxiety-related symptoms within the general medical population (Zigmond et al., 1983) in a clinical setting. However, there is strong evidence that this self-report questionnaire is a valid option to screen for anxiety and depression symptoms caused by common mental disorders (Skapinakis, 2023). A study conducted by Bjelland et al. (2002) confirmed that the Hospital Anxiety and Depression Scale is a valid screening tool for mood and anxiety disorders in comparison to other screening tools such as the patient health questionnaire and depression, anxiety and stress scale. The Hospital Anxiety and Depression Scale is relevant in a variety of contexts, such as the community, hospital, and outpatient practices. Important to keep in mind that self-report questionnaires were developed for screening of symptoms and should not be used for diagnostic purposes (Snaith, 2003).

2.6.1.3 Conditions leading to the need for an occupational evaluation

Standardised assessment and self-report questionnaires are used during the evaluation phase to screen and determine the impact symptoms associated with common mental disorders have on the person diagnosed with a common mental disorder. To that end, it is argued that the assessment process of clients is a complex

interplay of environmental and client factors, which both impact the person's occupational performance and engagement within occupational roles.

2.6.1.4 Changes that occurred to specific mental functions as a result of common mental disorders

Specific mental functions are body functions that include lower and higher cognitive functions, mental functioning with sequence, emotions, and self-awareness (American Occupational Therapy Association, 2020). The changes that occur to these mental functions will be discussed below as per each common mental disorder.

The term ‘common mental disorders’ is used to describe various psychiatric conditions, namely major depressive disorder, bipolar mood disorder, post-traumatic stress disorder, generalised anxiety disorder and substance use disorder (Meyer et al., 2019). These disorders’ symptoms range from mild to severe and last for months or years (Boland et al., 2024). A distinguishing factor between the duration of mood and anxiety disorders is that mood disorders tend to be more episodic, whereas anxiety symptoms are more chronic. The exact duration and symptom severity fluctuated based on each condition (World Health Organization, 2017). The development of common mental disorders is unclear; however, it can be concluded that genetics, as well as environmental factors, divided into familial as well as individual-specific environmental factors, contribute towards the development of these conditions (American Psychiatric Association, 2022). Common mental disorders are considered chronic conditions having a high tendency to follow a recurrent episodic pattern of remission and relapse. Mental healthcare users diagnosed with a common mental disorder are prone to experiencing several debilitating episodes of symptoms throughout their lives. The duration of the relapse phase is non-specific and can last for months to years. The longer the relapse episode, the higher the proclivity of the symptoms becoming more permanent, causing psychosocial disability (van Niekerk et al., 2020).

Psychosocial disability is the term used to describe disability caused by mental disorders. It restricts independent activity participation and engagement within occupational areas (activities of daily living, instrumental activities of daily living, work,

leisure, sleep and rest, play, education, social participation and leisure). A psychosocial disability is usually a period of temporary incapacity. During the remission phase of the illness cycle of common mental disorders, mental healthcare users may obtain complete independence (van Niekerk et al., 2020).

A. Mood disorders

There are three different mood states, namely, depression, euthymia, and mania or hypomania. Depression is associated with a depressed or low mood, whereas bipolar disorder is the fluctuation between depression mania and or hypomania. Mental healthcare users suffering from mood disorders are unable to maintain a euthymic mood state without the assistance of pharmacotherapy due to chemical imbalances within the neurotransmitter pathways (Boland et al., 2024). Mood disorders impact volition, social interaction, appetite, sleep, self-worth, emotional regulation, and cognitive output (American Psychiatric Association, 2022; Falk et al., 2023).

A study conducted by Trifu et al. (2020) found that structural changes to the hippocampus, thalamus, cortical grey matter, limbic system, amygdala and monoaminergic neurotransmitters due to depression cause mental function changes. These changes include impairments in working memory, information processing, inhibition control and emotional regulatory and behavioural responses. Modulation of pain, aggression, libido and eating patterns is impacted. A study conducted by Hammar et al. (2022) identified significant neurocognitive decline, which occurs during the onset of this condition and remains even if the client's mood stabilises. Between 25% -75% of mental healthcare users diagnosed with depression suffer from cognitive deficits. The severity of these symptoms is determined by the onset and duration of symptoms, as well as the treatment rendered. Depression causes functional impairments within the occupations of work, social participation and interpersonal functioning. Cognitive deficits remain despite remission as well as intensify during each relapse phase, over time and with age (Hammar et al., 2022).

Cognitive functioning is subdivided into domains consisting of memory, executive functioning, and attention (Harvey, 2019). Memory deficits are the inability to code, retain and retrieve verbal, auditory and written information. Cognitive processing

difficulties (reduced processing speed) are postulated to be a contributing factor towards memory impairments (Hammar et al., 2022). These impairments limit the learning prospects of a person diagnosed with a common mental disorder. These difficulties reduced productivity at work and the ability to master new work tasks as well as recall important information needed to perform work tasks (Hammar et al., 2022). Executive functioning deficits are common among mental healthcare users diagnosed with depression. Defects within this domain prevent the successful development of plans, solving problems, regulating emotions, inhibiting negative thoughts and refraining from displaying emotionally impulsive behaviour (Warren et al., 2020). Inhibition control related to executive functioning is a prognostic factor indicating the possibility of relapse in the future. Reduced inhibition control during the acute phase is associated with relapse (Hammar et al., 2022).

Attention is a cognitive function that forms part of most daily tasks. To complete tasks accurately, it is important to be able to focus for the duration of the task. Deficits in attention prevent the maintenance of focus during daily tasks such as reading, performing work tasks, cooking, cleaning, etc. Reduced attention influences interpersonal relationships by the inability to focus during conversations, contributing to communication errors (Hammar et al., 2022). South Africa's labour market has a high prevalence of depression amongst employees, estimated to be one in every four employees experiencing depression. Stander et al. (2015) found that cognitive impairments associated with depression and anxiety are the symptoms mainly linked to higher absenteeism from work as well as poor productivity when present at work.

B. Anxiety Disorders

Anxiety disorders are classified as generalised anxiety disorders as well as specific phobias. Generalized anxiety disorder consists of persistent worry or fear about various topics and eliciting physiological changes to occur, causing the following symptoms: restlessness, fatigue, cognitive fallouts in attention and memory deficits, emotional dysregulation, inclusive of irritability, increased experience of muscular pains and insomnia (American Psychiatric Association, 2022). Specific phobias are fears of a specific object or situation that elicit a stress response. Exposure to these

objects or environments leads to an immediate experience of intense anxiety, resulting in avoidant behaviour (American Psychiatric Association, 2022).

Lukasik et al. (2019) found that anxiety reduced working memory. Furthermore, sensory processing is the ability to register, modulate and organise sensory information to respond to various environmental demands. It is the ability to shift focus to and from environmental sensory input to enhance task execution. Stress or anxiety may increase sensory sensitivity, preventing sensory modulation (Harrold et al., 2024). It has become apparent that sensory regulation has an impact on occupational engagement within daily tasks and negatively impacts mental healthcare users. A direct link has been established between sensory processing difficulties or impairments and mental illnesses such as post-traumatic stress disorder, anxiety and schizophrenia (Andersson et al., 2020). Individuals diagnosed with these conditions find it difficult to filter out or down-regulate sensory input, limiting active focus on daily tasks. People diagnosed with a common mental disorder struggling with sensory processing are easily distracted by external environmental triggers such as sound, noise, and smells, which prevents task-focused behaviour, contributing to unproductivity within the workplace (Andersson et al., 2020). Limited research has been done on the number of persons diagnosed with a common mental disorder recovering after being placed on incapacity leave.

C. Post-traumatic stress disorder

The development of posttraumatic stress disorder within the South African context has a strong correlation with the high crime rate. South Africa is one of the countries with the highest rate of violent crimes worldwide. Exposure to violent crimes such as sexual assaults, armed robberies, hijackings, home invasions and trauma perpetuated the development of posttraumatic stress disorder within this context. Additionally, the South African population's societal factors, such as unemployment, poverty, and social inequality, further increase the prevalence of posttraumatic stress disorder within this population (Africamindsmatter.org, 2024). Post-traumatic stress disorder is classified as a stress/trauma-related disorder causing internal distress that disrupts daily functioning, stemming from exposure to trauma. Symptoms associated with this

condition are intrusive (flashbacks, nightmares or recurrent vivid memories of the event), avoidant behaviours (thoughts, objects, events and/or people linked to the trauma are avoided), negative alterations (cognitive distortions, false beliefs) as well as mood-related symptoms, and lastly hyperarousal (hypervigilance) (American Psychiatric Association., 2022). Post-traumatic stress disorder has a debilitating impact on daily functioning (Jellestad et al., 2021). Furthermore, there is strong evidence that post-traumatic stress disorder is associated with the development of dementia (de Araujo Junior et al., 2023). Thus, posttraumatic stress disorder contributed significantly to cognitive decline within the population of people diagnosed with a common mental disorder.

D. Substance Use Disorder

South Africa is rated fifth on the list for the highest consumption of alcohol. Furthermore, the South African population has a higher disposition towards the use of illegal substances such as methamphetamines. The high use of substances amongst the population is of great concern as it has a noteworthy impact on the crime rate, especially violent crimes (Price, 2024). Substance use disorder is classified as a neuropsychiatric condition characterised by continuous engagement in certain behaviours and/or consumption of addictive substances (Zou et al., 2017). Prolonged use of these substances negatively influences cognition and impulse control and increases risk-taking behaviour (Sadock et al., 2007). Substance use disorder negatively impacts executive functioning, attention, inhibition control, emotional regulation, working memory, decision-making, and downstream motivational processes (rewards and stress) (Ramey et al., 2019). Substance use directly impacts work performance, resulting in higher absenteeism from work, poorer work performance due to cognitive decline and behavioural changes associated with substance use (Olivier et al., 2019).

2.6.1.5. Conclusions drawn from the assessment

After the assessment has been conducted, the occupational therapist combines subjective and objective assessment data to conclude and develop client-specific recommendations (Crouch et al., 2014; American Occupational Therapy Association,

2020). Work is a central occupation within an adult's life, and due to changes within the client factor, the person diagnosed with a common mental disorder may not be able to return to work due to temporary psychosocial disability (van Niekerk et al., 2020). A study conducted by Ramano et al., 2018, on occupational therapists' perspective of return to work after performing a functional capacity evaluation amongst mental healthcare users suffering from major depressive disorder found that biographical data (such as age, gender as well as type of work), the employer and employees' opinion on return-to-work prospects, clinical judgment of the occupational therapist, impact of symptoms on functioning as well as motivation (consisting of intrinsic, extrinsic as well as level of creative ability) influences recommendations for each client regarding return to work. A combination of return-to-work prospects, motivation, and occupational therapists' clinical judgment is used to determine if the client requires leave (sick or temporary incapacity leave), should return to work in their current position, or needs to be accommodated for a certain period. Reports for all multidisciplinary team members are used to apply for temporary incapacity leave.

2.6.2 Phase Two – Intervention

Rehabilitative services have been found to have long-term health, social and economic benefits within the South African context; however, a great concern is that these services are run separately from primary health (Louw et al., 2023). The occupation of work forms an integral part of the occupational therapist's treatment plan and is referred to as vocational rehabilitation (rehabilitation focused on getting the client back to work).

Within the South African context, funding for vocational and return-to-work rehabilitative services should be done through the Department of Labour. However, in reality, vocational rehabilitation is funded by the private sector through the insurance industry or medical schemes (Occupational Therapy Association of South Africa, 2020). Funding remains a significant problem within the field of vocational rehabilitation due to a lack of resources. A lack of early intervention and return to work has been associated with poorer vocational prognosis (likelihood of return to work after the period of absence) (Frank, 2016).

2.6.3 Phase Three – Outcomes After phases one and two have been conducted, a revaluation using the predetermined outcome measure is used to establish the progress of the person diagnosed with a common mental disorder (American Occupational Therapy Association, 2020). Clinically, it has been observed that a majority of the clients that were initially assessed come for treatment due to various reasons, of which finances are the main reason. Few of the patients initially assessed completed the occupational therapy process.

2.7 Conclusion

Occupational therapy is a client-centred profession focused on promoting health, well-being, and independent engagement in various occupations (basic and instrumental activities of daily living, work, leisure, social participation, and sleep) (World Federation of Occupational Therapists, 2012; Occupational Therapy Association of South Africa, 2023). Occupational therapists treat clients following the internally recognised occupational therapy process. Based on the Occupational Performance Model (Australia), occupational therapists believe that the person and the environment are interrelated, which fosters occupational engagement (Chapparo et al., 1997; Ranka et al., 2011). Amongst the adult population, work forms part of their key daily activities. The individual draws meaning from work through the establishment of a work identity, engaging socially with colleagues, and developing a sense of authenticity. However, the work environment can also present the employee with barriers towards the maintenance of a healthy state of mental well-being. Poorer mental well-being has been associated with unproductivity at work, higher absenteeism, cognitive decline and ultimately the development of a common mental disorder.

Common mental disorders are linked to significant cognitive decline, reduced motivation as well as the inability to productively engage within the occupation of work. Cognition and motivation play a vital role in productive engagement within the occupation of work. As indicated by the occupational performance model (Australia), changes in cognition will have a direct impact on occupational performance. Occupational performance in some instances due to psychosocial disability caused by common mental disorders reduces the individual functioning to such an extent that

their production level is incompatible with key performance areas associated with the nominated occupation/job, resulting in the need for the application of temporary incapacity. Temporary incapacity leave extracts the person diagnosed with a common mental disorder from the occupational area of work, reducing the benefit of work and ultimately leading to a loss of occupational work identity, but with reduced remuneration, usually 75%. Perpetuating the person diagnosed with a common mental disorder's psychological symptoms, inclusive of further cognitive decline.

The occupational therapy process is well-established however, funding poses a significant barrier towards the South African workforce, whose work is compromised by illness and having access to occupational therapy services. There is strong evidence that early intervention has a positive impact on vocational prognosis and return to work prospects. However, if vocational rehabilitation is not prioritized by the various stakeholders, inclusive of the client, insurance companies, occupational therapists, medical aids and the Department of Labour. In addition to rehabilitation forming part of the primary management of common mental disorders, it is hypothesised by the researcher that permanent psychosocial disability as a result of depression, anxiety, posttraumatic stress disorder and substance use will continue to be a significant and costly problem within the labour market. It remains the occupational therapist's responsibility to advocate for these services and provide evidence-based research to motivate these services.

CHAPTER 3: METHODOLOGY

3.1 Introduction

This chapter describes the research process that was followed to explore the effects of temporary incapacity leave (3 to 24 months) on specific mental functions among people diagnosed with a common mental disorder in the Eastern Cape, South Africa. The chapter has been organised to cover the research paradigm, design, and procedures used in this study to meet the four objectives set out in Chapter 1, as well as the methods to ensure the rigour of the study, ethical considerations, and data analysis.

3.2 Research paradigm.

This study utilised a positivist research paradigm. The positivist research paradigm uses the postulation that a functional relationship is present between research variables. Within the context of this study, the researcher holds the viewpoint that the research variables have a causal relationship (Park et al., 2019). Research variables such as need for and period of incapacity leave are dependent on the individual's specific mental functions, compatibility with the work demands of the individual's nominated occupation. The study was based on the ontological assumption that the knowledge that would contribute to answering the research question lay within pre-existing client clinical data used to apply for incapacity leave, which had not yet been previously examined and interpreted. This research paradigm supports using a quantitative retrospective record review as the methodology for this study.

3.3 Research design

This study used a quantitative research process in a retrospective record review design to analyse (Brink et al., 2018) occupational therapy patient records over 10 years from 2014 to 2024. The occupational therapy records studied were those of persons diagnosed with a common mental disorder who were assessed to assist in determining the need for temporary or permanent incapacity leave as a personal or employer insurance benefit following a common mental disorder. Demographic and

symptomatic variables were extracted from the historical records over this period and analysed scientifically to describe the changes that occurred over time, explore associations between the specified variables, and draw conclusions related to the purpose and aim of the study. A retrospective record review was, thus, an appropriate method to collect data for this study and is an accepted methodology used in many fields of medical sciences to examine patterns of care and healthcare outcomes (Sarkar et al., 2014).

3.4 Research context

Research data was obtained from assessments conducted at a private occupational therapy practice. The practice employs 12 occupational therapists, half of whom provide services at an acute psychiatric private facility in Gqeberha, such as running group therapy sessions and short-screening occupational therapy assessments to determine if the clients would benefit from outpatient occupational therapy services.

The other six occupational therapists work in an outpatient setting at the practice located in Gqeberha. The practice's primary focus is psychiatric vocational rehabilitation, where most persons referred have a diagnosis of a common mental health disorder. Services rendered at the outpatient practice consist of assessing the clients to determine functional impairments. Thereafter, intervention strategies are implemented to address the impairments to restore independence and facilitate a return to work.

The vocational rehabilitative service rendered by the occupational therapists employed by the private practice consists of managing clients on temporary incapacity leave. These clients undergo a baseline occupational therapy assessment to determine if, at the time of the assessment, their cognition (cognitive functions needed to perform their key work tasks) and psychological profile (volition and anxiety levels) are compatible with their work demands. The client's psychological profile is determined by subjective information derived from self-report questionnaires and background information, as well as objective information, clinical judgment of the experiences occupational therapist employed by the practice. Self-report

questionnaires that are selected based on background information given by, as well as the diagnosis of the client. The occupational therapist within the practice uses a variety of questionnaires. These questionnaires are not always repeated, and for this reason, could not be used in the study as there were no comparative data available. The assessments are funded privately by the client, either as a cash patient or through medical aid. The medical aid billing codes most often used are 66108, 66109, 66211 and 66401 for a full functional capacity evaluation. Functional capacity assessments are also funded by the insurance company, where each company predetermines the amount payable for the assessment, and they each have their own billing codes.

Performance on standardised assessments, objective and subjective information obtained during the interview process, in addition to self-report questionnaire scores, are compared to the client's job work duties. In some cases, depending on the need and consent of the client, the employer is contacted for collateral information. The occupational therapist then performs a job analysis where the abovementioned factors are compared to the client's work demands to determine if they can productively engage in work tasks. Additionally, the therapist uses the data obtained from the job analysis to determine if the client needs to be accommodated at work. Assessment results and subsequent clinical reasoning determine if the client is able or unable to productively engage within their work environment. The client submits the reports from their occupational therapist and psychiatrist to their employer.

If it is deduced that they are unable to return to work at the time of the assessment, a temporary period of incapacity leave due to ill-health is recommended by the occupational therapist and then supported by the client's treating psychiatrist. The employer then applies for insurance benefits on behalf of the client if a pre-existing insurance policy is in place. The insurer employs case managers consisting of medical professionals. Case managers are responsible for approving and managing claims for temporary incapacity leave. If the insurer approves the benefits, then the claimant receives a portion of their salary, usually 75%. Each case is reviewed every six months until the client returns to their nominated occupation or an alternate job on the open labour market. During each review, an occupational therapy report is needed to

determine if the client's symptoms remain functionally impairing and incompatible with their work demands.

A high percentage of the clients assessed within the practice receive recommendations to attend outpatient occupational therapy sessions to facilitate their recovery post-discharge. However, few patients attend due to financial restraints as these sessions have to be funded by the clients themselves, either privately or through daily medical aid benefits. If the client is ready to undergo vocational rehabilitation, the occupational therapist can contact the insurer to motivate payment for sessions. However, the insurers only fund vocational rehabilitation (which is an intervention strategy aimed at getting the person diagnosed with a common mental disorder back to work). Funding by the insurer is case-specific.

3.5 Population and Sampling

3.5.1 The population

In the context of this research, the population does not refer to people but to the specific group of records that were examined. Thus, the population was all the records of adult persons diagnosed with common mental disorders whom occupational therapists had assessed for incapacity leave over 10 years (2014-2024).

3.5.2 Sampling

The sampling method used in this study was purposive sampling, as records selected for this study needed to comply with specific inclusion and exclusion criteria to meet the research objectives (Bhardwaj, 2019).

The sample of records was selected based on the inclusion criteria listed below.

3.5.2.1 Inclusion criteria

Records that met the following criteria were included in this study.

The records were included if the person was:

- Between the ages of 18 and 65, which is considered the working age within South Africa.
- Diagnosed by a psychiatrist with a common mental disorder such as anxiety, depression, substance use or bipolar mood disorder.
- Recommended for or on temporary incapacity leave extending past three months up to two years.
- Were employed/ self-employed within the South African open labour market when the baseline assessment was conducted. Unemployed individuals would not require incapacity leave, and for this reason, only employed adults were considered for the study.

3.5.2.2 Exclusion criteria

Records were excluded if the person was diagnosed with common mental disorders:

- Had relapsed or had been readmitted to a psychiatric facility during the research period as a relapse could perpetuate cognitive, anxiety and mood-related symptoms, which in turn could be the factor causing the deterioration of specific functions instead of the incapacity leave period.
- Had a comorbid neurological or psychotic illness, which has additional functional implications. Psychosis is also likely to negatively impact cognitive functions in the long term as well as neurological or neurocognitive conditions such as a stroke, dementia or Alzheimer's.

3.5.3 Sample Size

Approximately 200 assessment reports that met the inclusion criteria had been gathered over the specified ten-year period. The sample calculator by Raosoft (2004) was used to determine the sample size of records that needed to be analysed at a 95% confidence level and with a 5.0% marginal error. The sample size required that 132 records be reviewed.

3.6 Research process

The research study was conducted according to the steps below:

Step 1: The research question and problem were identified.

The researcher first observed the research problem within the clinical field while working as an occupational therapist. Literature concerning the problem was reviewed to investigate the problem. A combination of both clinical observations as well as literature was used to formulate the research problem and question.

Step 2: A research proposal was developed and submitted for approval by the Faculty of Health Sciences Research Committee of the University of Witwatersrand.

The researcher developed an Ethics proposal document, which was submitted for ethical clearance. Ethical clearance was obtained from the Faculty of Health Sciences of the University of the Witwatersrand (Ethical clearance number M230639; See Appendix D).

Step 3: An in-depth literature review was conducted.

To compile the literature review, an in-depth review of the literature related to the problem statement, research title, and objectives was conducted.

Step 4: A data collection extraction tool was developed.

The researcher predesigned an Excel spreadsheet used as the data extraction tool. The Excel sheet consisted of three separate sheets. The first sheet recorded all non-identifiable demographic information such as age, gender, diagnosis, employment status and information. The second sheet recorded the times of each assessment and scores of the Hospital Anxiety and Depression Scale, Zung Self-Rating Depression Scale, and Zung Self-Rating Anxiety Scale. The last sheet recorded scores obtained from the Repeatable Battery for the Assessment of Neuropsychological Status at the time of each assessment. Please see Appendix B for an example of the data extraction tool.

Step 5: Data analysis and interpretation

The data was imported into a statistics program. Statistical data was then grouped to answer each research objective. Tables and graphs were created to represent these groupings. The statistical results, combined with relevant literature, were used to discuss and explain the outcome of each objective under the discussion section.

3.6.1 Data collection

Retrospective data were collected from the assessment records of the mental health users at the research site as described above in section 3.2. The data were collected from the assessment records as reported by the occupational therapist responsible for each mental health care user diagnosed with a common mental disorder.

The data were collected during the routine assessments of mental healthcare users referred for occupational therapy between 2014 to 2024. Within the Eastern Cape province of South Africa, 78.8% of the population speaks Isixhosa, 10.6% speaks Afrikaans, and 5.6% speaks English (Government of South Africa, 2023). Amongst the occupational therapists employed at the private practice, all were fluent in English and some in IsiXhosa and Afrikaans. The test instructions are presented in English; however, on the rare occasion when the client is unable to understand English, the therapist may explain the test instructions in a language the client most easily understands.

The specific data extracted from the records of the persons diagnosed with common mental disorders that met the inclusion criteria consisted of the following:

3.6.1.1 Demographic information

The demographic data that were collected from the patient records included age, gender, diagnosis, comorbid diagnosis, and the client's occupation. Additional occupation-related information was the type of leave (either temporary/ permanent) at the time of each assessment and return to work after the last assessment.

The data extraction instrument used in this study was a password-protected Excel spreadsheet. Data captured on the Excel spreadsheet was imported into REDCap (Patridge, 2018), the data management system used by the university.

Scores on two of the following three instruments were captured at the time it was performed. The times were captured and grouped in the following ranges: 3-6 months, 9-12 months, 15-18 months, and 21-24 months after the start of incapacity leave.

3.6.1.2 Standardised and self-reported questionnaire assessment data.

The following information was extracted from the client records and imported into the Excel spreadsheet. Index scores of all the subtests of the Repeatable Battery for the Assessment of Neuropsychological Status in addition to the raw scores of the subtest of either the Hospital Anxiety and Depression scale or the Zung Anxiety and Depression Self-Report Scale Each client record from baseline to the first and second reviews had the same mood and anxiety questionnaire. However, not all the client records had the same mood and anxiety questionnaire. The Hospital Anxiety and Depression Scale recorded the anxiety and depression scores for 98 records, and the ZUNG Self-Report Anxiety and Depression Scale was used to measure 65 of the client records. The occupational therapist uses their clinical judgment to determine which mood and anxiety scale would best suit the needs of the client. Factors that are taken into consideration when selecting a mood and anxiety screening tool are the education levels of the client, familiarity and fluency in English and cognitive capacities. The Hospital Anxiety and Depression Scale is easier to comprehend and uses basic English phrases and terminology, whereas the Zung Self-Report Anxiety and Depression Scale use more complex terms.

3.7. Assessment tools

The following tools were used to measure the client factors in the occupational therapy records.

3.7.1 Repeatable Battery for the Assessment of Neuropsychological Status

The Repeatable Battery for the Assessment of Neuropsychological Status (RBANS) is a widely used brief battery, employed as a core diagnostic tool in dementia and as a neurocognitive screening battery in a variety of other disorders in older adults. The assessment consists of 5 subtests measuring immediate and delayed memory, attention, visio-spatial skills and language. The assessment takes approximately 30 minutes to administer. Each subtest consists of two subscales, and the scores of these scales are used to determine an average score based on age-related normative data (Randolph et al., 1998).

Each subtest's index score is calculated by using the total raw score of each subscale and comparing these scores with age-related normative data to determine the index score of each subtest. The subtests, subscales and maximum achievable scores under each test are reflected in Table 3.1. (Randolph et al., 1998).

A meta-analysis performed by Shura et al. 2018 found that the RBANS has high content validity and accurate diagnostic abilities within various populations.

The index scores of each subtest are added together to get an accumulative value. The accumulative value is used to determine the overall functional score by converting the total index score by using Table 3.1 in the RBANS manual to find the overall functional score.

The 12 occupational therapists employed at the private practice conducted the assessments that contributed to this research. They were all qualified occupational therapists registered with the Health Professions Council of South Africa, and each had more than three years of experience working with persons diagnosed with common mental disorders at a private practice. This includes the observation of at least three experienced occupational therapists performing this assessment based on the test's instructions, completing the test on a pre-recorded case and scoring the test using the test manual until they match the scores of the experienced tester. This will ensure inter-rater reliability (Mwenge et al., 2022).

3.7.2 Hospital Anxiety and Depression Scale

The Hospital Anxiety and Depression Scale is a 4-point scale questionnaire ranging from 0 to 21. This self-report questionnaire is divided into two sections, one for anxiety and the other for depression. Each subscale has 7 questions. Scores range from 0-21, with scores between 0-7 considered normal, 8-10 borderline and 11-21 abnormal (Stern, 2014). The Hospital Anxiety and Depression scale is scored as follows. The scale is divided into two main subsections: anxiety and depression. The anxiety and depression sections each consist of seven questions, and each question has four possible categories to select from. The client circles the score representing their current experience of anxiety or depression symptoms. Each question scores under the two subsections are counted together to get an accumulative value representing the total score (Stern, 2014).

3.7.3 The Zung Self-Rating Depression Scale and Zung Self-Rating Anxiety Scale

The Zung Self-Rating Depression Scale and Zung Self-Rating Anxiety Scale were developed by Zung to measure the intensity of anxiety and depression symptoms. Each questionnaire consists of ten positively and ten negatively worded questions. Scores for each question range from 1- a little to 4, most of the time. A total score is calculated and based on severity levels is classified within normal ranges (25-49), mild (50-59), moderate (60-69) and severe 70 and above. The Zung Depression Self-Rating Scale is determined by a cumulative value of all of the responses for each of the 20 questions. Each question is divided into 4 possible responses, the responses are each allocated in numerical value ranging from 1 to 4. For questions 2, 5, 6, 11,12, 14, 16, 17, 18 and 20, scoring is reversed. The scoring is reversed as follows: a one becomes a four, two a three, three a two, and four a one. The score of each question is accumulated to get a total score. The Zung Anxiety Self-Rating Scale's total score is calculated the same as in the Zung Depression Self-Rating Scale, except for reversed questions (5, 9, 13,17 and 19).

3.8 Data analysis

Client records from the private practice were reviewed to determine if the information was in line with the inclusion and exclusion criteria of the study. Information from these records was de-identified and imported into an Excel spreadsheet (data extraction tool) (see Appendix B). When information was not in a numerical form, a coding system was used, and the non-numerical information was given a numerical value. The data was then run in the TIBCO Statistica v 14.1 (TIBCO Statistica, 2023) program to calculate descriptive statistics in terms of frequencies.

Demographics, as well as the raw scores on the Repeatable Battery for the Assessment of Neuropsychological Status, Hospital Anxiety and Depression Scale and Zung Self-Report Anxiety and Depression Scale and the change in anxiety, depression and cognition scores on these tests over three assessment periods of Temporary Incapacity Leave (TIL), were included. Change in the scores for anxiety, depression and cognition was considered based on an improvement or no change which included a change in scores below the Minimal Clinically Important Differences (MCID) and deterioration on each of the tests used (MICD: Repeatable Battery for the Assessment of Neuropsychological Status = 8.21, Hospital Anxiety and Depression Scale = 1.7, Zung = 4.9).

Tables, as well as graphs, were used to represent this data in Chapter 4.

Inferential statistics using the non-parametric Mann-Whitney U test were used to compare the ordinal raw scores on the Repeatable Battery for the Assessment of Neuropsychological Status, Hospital Anxiety and Depression Scale and Zung Self-Report Anxiety and Depression Scale and the change in anxiety, depression and cognition on these tests over the three assessment periods according to the return to work and whether the records indicated Permanent Incapacity Leave (PICL) was granted.

The change in the ordinal scores on the Repeatable Battery for the Assessment of Neuropsychological Status, Hospital Anxiety and Depression Scale and Zung Self-Report Anxiety and Depression Scale for each of the participants were correlated with

the time of their first and second reviews to determine if there was an increase or deterioration in anxiety, depression and cognition over time.

3.9 Data management

Data which were deidentified were extracted from the person diagnosed with a common mental disorder from occupational therapy records and were recorded on an Excel spreadsheet (data extraction tool), which was then imported into REDCap (Patridge, 2018). a secure database of the University of the Witwatersrand for storing and protecting research information. Organisational consent forms, client consent forms, ethical clearance documents and permission letters were also stored on REDCap for a predetermined time frame of 6 years if not published and 2 years if the data is published as recommended by the Health Professional Council of South Africa.

3.10 Rigor of research

Assessment results were obtained from standardised assessments and self-report questionnaires routinely used as part of the Incapacity Leave Assessment protocol used by the practice. The assessments and self-report questionnaires each have their internal validity and reliability described under 3.4. The standardised assessments, such as the Repeatable Battery for the Assessment of Neuropsychological Status, and self-report questionnaire inclusive of the Hospital Anxiety and Depression Scale, Zung self-report depression Scale and Zung Self-Rating Anxiety Scale all possess internal validity and are diagnostically accurate (Bjelland et al., 2002; Shura et al.,2018). However, external validity can be influenced by non-standardised test administration as well as the client's understanding of and ability to follow instructions. To limit selection bias and noticeable infringements on external validity, clear inclusion and exclusion criteria have been identified.

3.11 Ethical considerations

This study was approved by the graduate committee of the Faculty of Health Sciences of the University of the Witwatersrand and given Ethical approval from the Faculty of Health Sciences Human Research Ethics Committee (Medical) (Ethical clearance

number M230639) (See Appendix C). A letter of permission to undertake this research was provided by the practice owner (See Appendix D). As the researcher utilised retrospective records as the source of the research data, there was no direct contact with the research sample. Informed consent was obtained from the person diagnosed with a common mental disorder through the practice consent form collected from patient treatment consent forms (See Appendix E), which states that all assessment data may be used for research purposes and will be de-identified to the extent that the individual client cannot be re-identified. Thus, consent was not explicitly given for this study, as data were collected before the conceptualization of the study. Informed consent was obtained from the practice owners to access records for research purposes, with the understanding that consent could be withdrawn at any time during the study. (See Appendix D and E).

The following steps were taken to protect personal information according to the Protection of Personal Information Act 14 (2013) and ensure the confidentiality of study data. Only necessary data needed to answer the research question were extracted, anonymised and numerically coded to ensure that a person diagnosed with a common mental disorder's personal information always remained confidential.

The private practice currently stores all records on a secure server called LogBox that is password-protected; only the necessary staff are privileged to access this information. All records were viewed on this database, and no files were downloaded during the research study. The Excel spreadsheet (data extraction tool) was compiled on the researcher’s laptop and was password protected, and all research data were either stored on the database of the practice or REDCap (Patridge, 2018).

3.12 Conclusion

This chapter describes the retrospective record review that was conducted to answer the research question, aim and objectives highlighted in Chapter 1. Results obtained from the statistical analysis of the data recorded on the research extraction tool were used and organised according to the four research objectives and will be reported in the results chapter.

CHAPTER 4: RESULTS

4.1 Introduction

This chapter reports the results of the data that were analysed in the retrospective record review process discussed in Chapter 3. This chapter has been structured to first report on the demographic data collected from the records of the 162 people diagnosed with common mental disorders that met the inclusion criteria and were included in the study. The assessment results will then be reported as per the four objectives of the study.

4.2 Demographic information

4.2.1 Personal demographics

This section details the demographic data extracted from the analysed records of 162 persons diagnosed with common mental disorders.

Table 4.1 Age and gender of participants on record (N= 162)

	Aspects	n	Percentage
Age-bands	21-30	5	3.08
	31-40	30	18.45
	41-50	72	44.28
	51-60	53	32.60
	61-65	2	1.23
Gender	Male	93	57.20
	Female	69	42.44

The ages extracted from the records have been divided into age bands of 10 years. As seen from Table 4.1, the age band with the highest number was 41-50 years (n=72; 44.28%), and the lowest number was 2 in the age band 60-65 (1.23%). The combined age bands 41-60 had the highest number of persons diagnosed with a common mental disorder (n=125; 76.88%). Table 4 also reports that the sample included more males (n=93; 57.20%) than females (n=69, 42.44%).

4.2.2. Medical information

This section details the medical information extracted from the 162 records.

Table 4.2. Common mental disorder diagnosis (N=162).

Common mental disorder	Level of diagnosis					
	Primary		Secondary		Tertiary	
	n	Percentage	n	Percentage	n	Percentage
Bipolar Mood Disorder	51	31.37	6	3.69	0	0
Major Depressive Disorder	69	42.44	17	10.46	4	2.46
Post-traumatic stress disorder	40	24.60	15	9.23	2	1.23
Generalised Anxiety Disorder	2	1.23	20	12.30	4	2.46
No secondary diagnosis	0	0	104	63.96	152	93.48

The most frequent disorder was major depressive disorder (n=69; 42.44%), the second highest was bipolar mood disorder (n=51; 31.37%), followed by post-traumatic stress disorder (n=40, 24.6%). Generalised anxiety disorder was the least frequent diagnosis recorded within the sample. Of the primary diagnoses, mood disorders (n=90; 55.35%) were the most common diagnoses within the sample.

A total of 104 of the 162 records did not record a co-morbid or secondary psychiatric diagnosis. Only 58 of the sample had a secondary condition recorded, of which the highest was generalised anxiety disorder (n=20; 12.30%).

A small percentage of the sample (n=10; 6.15%) had a tertiary psychiatric diagnosis, which included major depression, post-traumatic stress, and generalised anxiety disorder. Bipolar mood disorder was not diagnosed as a tertiary condition within this record sample.

4.2.3. Occupational (work) Information

This section details the occupational information and return-to-work outcome reported after the last assessment from the records of 162 people diagnosed with common mental disorders.

Table 4.3 Work History and leave type recommended and return to work after the last assessment (N=162).

Aspects	n	Percentage
Occupation		
Educator	21	12.92
Police officer	11	6.76
Correctional officer	43	26.44
Nurse	9	5.54
Medical professionals	2	1.23
General Assistant	1	0.62
Maintenance or physical labour	21	12.92
Clerical work (working in administration)	27	16.60
Managerial work (supervisor or manager of employees)	27	16.60
Leave type recommended at the time of the last assessment.		
Temporary incapacity leave (Functional impairments are viewed as being temporary).	62	38.13
Permanent incapacity leave (functional impairments become permanent).	100	61.50
Return to work after last assessment.		
Yes	33	20.30
No	124	76.26
Recommended	5	3.08

As reported in Table 4.3 above, the occupation that was most frequently reported in the records reviewed was that of a correctional officer (n=43; 26.44%). The second most frequently recorded occupations were clerical work (work consisting of mainly administrative tasks) (n=27; 16.60%), educator (n=21; 12.92%), and maintenance or physical labour-intensive jobs (n=21; 12.92%). Over 61.50% of the records reviewed reported that temporary incapacity leave changed to permanent incapacity leave. The records reported that most of the sample (n=124, 76.26%) did not return to their nominated occupation or alternative employment on the open labour market.

4.2.4 Occupational therapy intervention after the baseline assessment.

Table 4.4 Referral and attendance of occupational therapy intervention after the baseline assessment (N=162).

	Aspects	n	Percentage
Clients referred for occupational therapy	Yes	153	94.10
	No	9	5.54
Clients who attended therapeutic intervention sessions	0	151	92.87
	1	2	1.23
	7	1	0.62
	8	2	1.23
	10	3	1.85
	12	3	1.85

Records reported that almost all the persons diagnosed with common mental disorders within the sample were referred for occupational therapy (n=153; 94.10%), and only n=9 were not referred for further intervention. However, very few people diagnosed with common mental disorders (n=11; 6,76%) were reported to have attended occupational therapy after the baseline assessment.

4.2.5 Time of each assessment

Table 4.5 Time in months when the baseline, first, and second review assessments occurred.

Months	**Baseline**		**First Review**		**Second Review**	
	N (162)	**Percentage**	**N (162)**	**Percentage**	**n (22)**	**Percentage**
0	162	100	3	1.85	0	0
3- 6	0	0	65	39.78	0	0
7-12	0	0	69	42.44	5	3.08
13-18	0	0	15	9.23	9	5.54
19-24	0	0	10	6.15	8	4.92

Table 4.5 reports that the baseline assessment occurred at month zero. The first review occurred most frequently between three and 12 months, and only 22 records reported a second review.

4.3 Cognitive Functioning reported from the results on the Repeatable Battery for the Assessment of Neurological Status over time.

This section reports the results of the data collected and analysed to address objective one:

> Determine the effect temporary incapacity leave (3 to 24 months) has on cognitive functions such as memory, attention, visual-spatial skills, and language of a person diagnosed with common mental disorders diagnosed with a common mental disorder in the Eastern Cape over time.

The results of the Repeatable Battery for the Assessment of Neuropsychological Status assessment at the different periods are reported according to subtests within this screening tool. Repeatable Battery for the Assessment of Neuropsychological Status scores are divided into six ranges as follows:

Table 4.6 Repeatable Battery for the Assessment of Neurological Status score ranges

Descriptive categories	Score ranges
Extremely low	>69
Borderline	70-79
Low average	80-89
Average	90-109
High average	110-119
Superior	120-129

4.3 1 Baseline, first and second review assessment

4.3.1.1. Overall functional score

As seen from Table 4.6, the baseline assessment's overall functional score of the Repeatable Battery for the Assessment of Neuropsychological Status for a person diagnosed with common mental disorders extracted from their records (N=162; 100%) was distributed among the three lowest descriptive categories (extremely low, borderline, and low average).

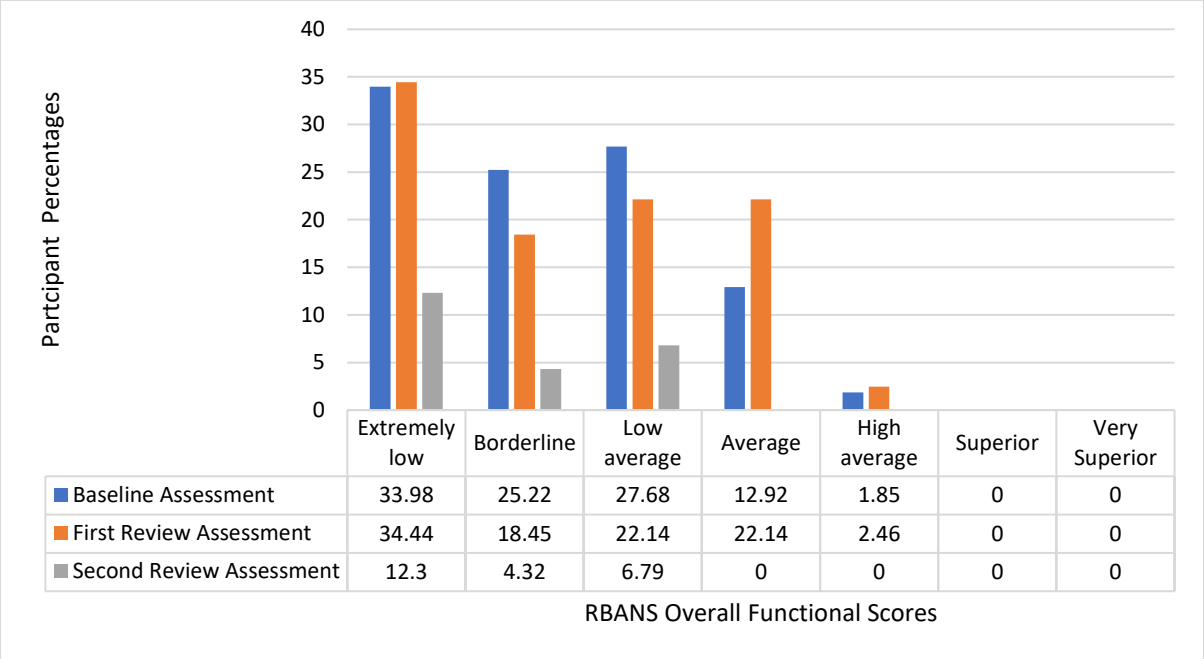
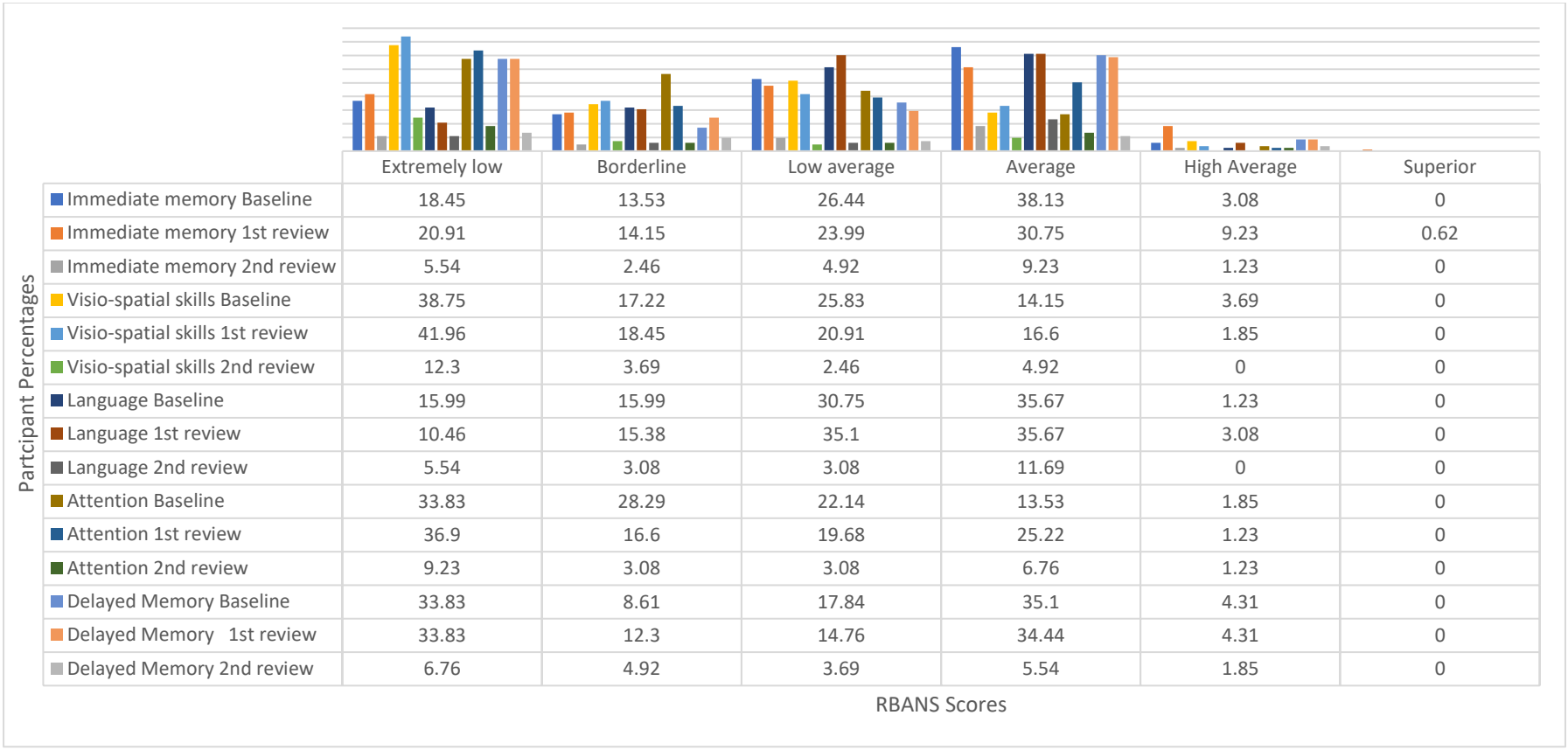


Figure 4.1 Repeatable Battery for the Assessment of Neurological Status Baseline, first and second review assessments for overall functional score

At the first review, although 14.77% (n=23) of scores fell into the average and above average descriptive categories, a slightly higher percentage scored (n=52; 33.98%) in the extremely low range. In the second review, all remaining participants' scores fell into the three lowest descriptive categories (extremely low, borderline and low average), which indicated that the sample's overall scores declined from the baseline assessment to the second review.

4.3.2 Subtests of the Repeatable Battery for the Assessment of Neurological Status.



	Extremely low	Borderline	Low average	Average	High Average	Superior
Immediate memory Baseline	18.45	13.53	26.44	38.13	3.08	0
Immediate memory 1st review	20.91	14.15	23.99	30.75	9.23	0.62
Immediate memory 2nd review	5.54	2.46	4.92	9.23	1.23	0
Visio-spatial skills Baseline	38.75	17.22	25.83	14.15	3.69	0
Visio-spatial skills 1st review	41.96	18.45	20.91	16.6	1.85	0
Visio-spatial skills 2nd review	12.3	3.69	2.46	4.92	0	0
Language Baseline	15.99	15.99	30.75	35.67	1.23	0
Language 1st review	10.46	15.38	35.1	35.67	3.08	0
Language 2nd review	5.54	3.08	3.08	11.69	0	0
Attention Baseline	33.83	28.29	22.14	13.53	1.85	0
Attention 1st review	36.9	16.6	19.68	25.22	1.23	0
Attention 2nd review	9.23	3.08	3.08	6.76	1.23	0
Delayed Memory Baseline	33.83	8.61	17.84	35.1	4.31	0
Delayed Memory 1st review	33.83	12.3	14.76	34.44	4.31	0
Delayed Memory 2nd review	6.76	4.92	3.69	5.54	1.85	0

Figure 4.2 Repeatable Battery for the Assessment of Neurological Status Baseline, first and second review assessments for Subtests (N=162

As reported in Figure 4.2 at baseline, just a third of people diagnosed with common mental disorders scored in the average and high average range for Immediate memory, language and delayed memory. The scores indicated that average function was achieved for visuo-spatial/constructional abilities and attention by 17.84% and 15.38% of participants, respectively. Attention was the subtest with the highest percentage of persons diagnosed with common mental disorders (62.12%), scoring between borderline and extremely low, indicating deficits were most significant for this attribute. A similarly high percentage of records (55.97%) were found to present with deficits in visuo-spatial/constructional abilities, while 42.44% had deficits in delayed memory. Fewer records were found to have deficits in immediate memory and language, with 26.44% and 30.75% scoring at borderline levels.

In the first review conducted mostly between 6-12 months after the baseline review, the percentage of records with deficits at borderline and extremely low increased slightly for immediate memory (35.06%), visuo-spatial/constructional abilities (60.14%) and delayed memory (46.13%). Fewer persons diagnosed with common mental disorders were reported to have language (25.84%) and attention deficits (53.50%) in this review. In the second review of the only 38 people diagnosed with a common mental disorder, a higher percentage reported deficit, scoring at a borderline or extremely low on all subtests except for immediate memory, where a higher percentage of people diagnosed with a common mental disorder (14.15%) scored at a low average or average level.

4.3.3 Change in scores on the Repeatable Battery for the Assessment of Neurological Status at Baseline, first and second review

Changes in the Repeatable Battery for the Assessment of Neuropsychological Status scores were determined for the overall total functional score and all subtests. See Figure 4.3. The minimal clinically significant difference (MCID) for the Repeatable Battery for the Assessment of Neuropsychological Status is an 8.4-point difference in scores, so persons diagnosed with common mental disorders with an increase or decrease in scores of 8.4 or less were classified as having a change that was not clinically relevant.

4.3.3.1 Changes in the overall functional score

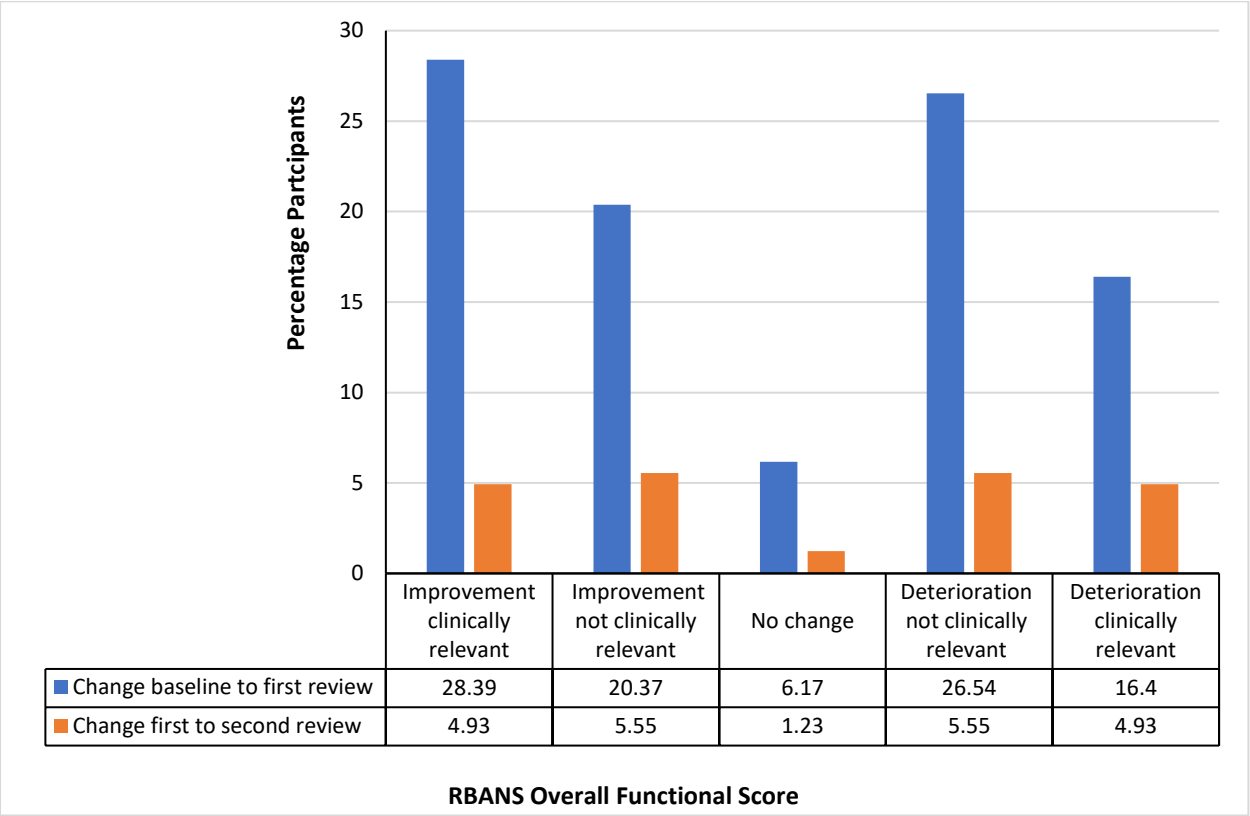
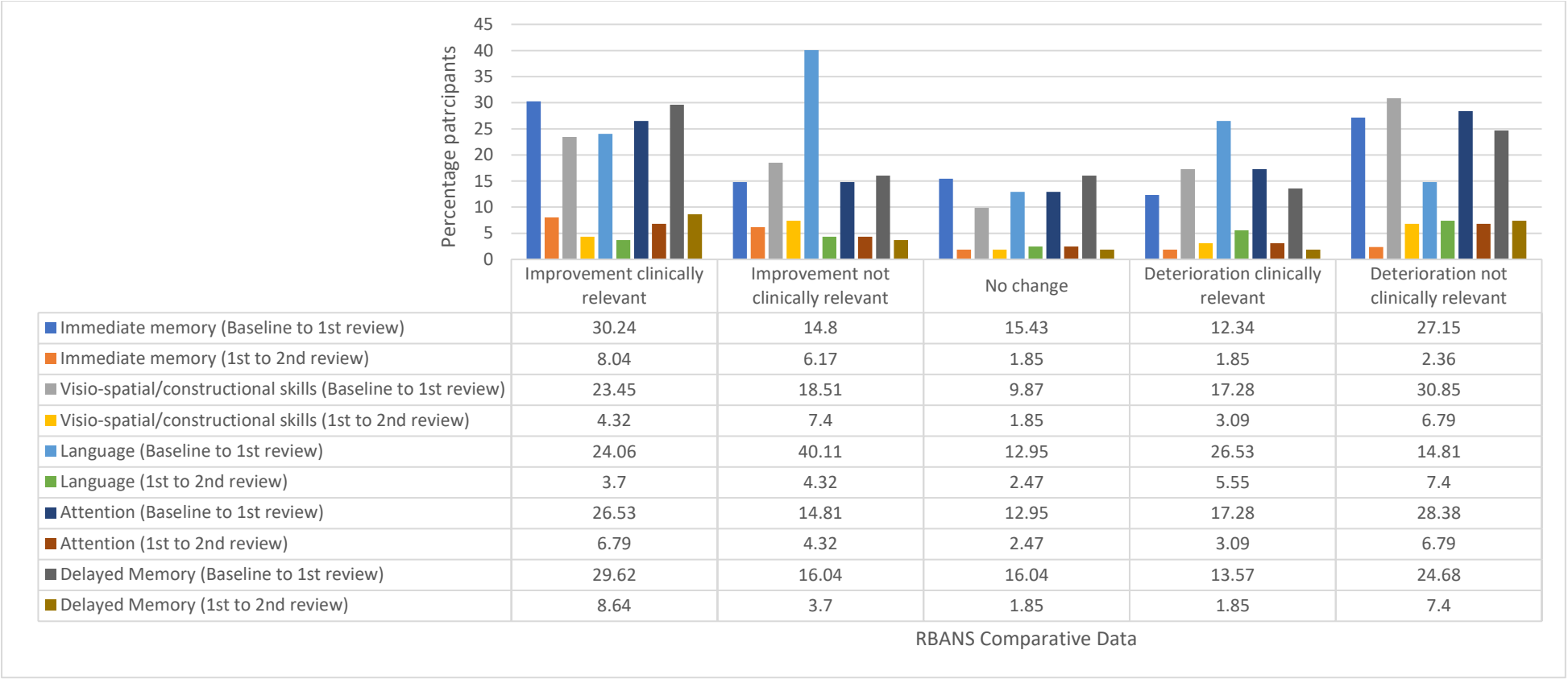


Figure 4.3 Changes on the Repeatable Battery for the Assessment of Neurological Status from baseline, first and second review assessments regarding the overall functional score (N-162).

Data on change from the baseline assessment and first review indicated that 28.39% of people diagnosed with a common mental disorder had clinically relevant improvement. In comparison, 16.4% were found to have clinically relevant deterioration in their scores for overall cognitive function. Most had minor changes in scores that were not clinically relevant for the Repeatable Battery for the Assessment of Neuropsychological Status. A similar finding for the 38 people diagnosed with a common mental disorder in the second review indicated that most showed no relevant clinical change, with the same percentage (4.93%) neither improving nor deteriorating clinically.

4.3.2.2 Changes in Subtests of the Repeatable Battery for the Assessment of Neurological Status (RBANS)



	Improvement clinically relevant	Improvement not clinically relevant	No change	Deterioration clinically relevant	Deterioration not clinically relevant
Immediate memory (Baseline to 1st review)	30.24	14.8	15.43	12.34	27.15
Immediate memory (1st to 2nd review)	8.04	6.17	1.85	1.85	2.36
Visio-spatial/constructional skills (Baseline to 1st review)	23.45	18.51	9.87	17.28	30.85
Visio-spatial/constructional skills (1st to 2nd review)	4.32	7.4	1.85	3.09	6.79
Language (Baseline to 1st review)	24.06	40.11	12.95	26.53	14.81
Language (1st to 2nd review)	3.7	4.32	2.47	5.55	7.4
Attention (Baseline to 1st review)	26.53	14.81	12.95	17.28	28.38
Attention (1st to 2nd review)	6.79	4.32	2.47	3.09	6.79
Delayed Memory (Baseline to 1st review)	29.62	16.04	16.04	13.57	24.68
Delayed Memory (1st to 2nd review)	8.64	3.7	1.85	1.85	7.4

RBANS Comparative Data

Figure 4.4 Changes on the Repeatable Battery for the Assessment of Neurological Status from baseline, first and second review assessments regarding the overall functional score (N-162).

Figure 4.4 reports the changes for all subtests on the Repeatable Battery for the Assessment of Neurological Status graphically. Within the immediate memory subtest, from baseline to the first review, the highest frequency of data was present within the outer ranges. This indicates that a clinically relevant improvement or deterioration occurred in more than half of the sample (57.39%). Data between the first and second review assessments showed that most of the sample's immediate memory improved.

Since the baseline assessment, 30.85% of the sample's visuo-spatial skills declined with clinical relevance. The abovementioned was consistent with comparing scores between the first and second review assessments.

More than 40% of the sample's language scores improved; however, the improvement was not clinically relevant between the baseline and review assessments. When considering the difference between the scores obtained in the first and second reviews, it was found that the highest percentage (7.40%) of the sample's language abilities deteriorated with clinical relevance.

The highest percentage of change was 28.4% of the people diagnosed with a common mental disorder, whose scores showed deterioration between the baseline and the second review in the attention subtest. In the second review, 6.8% of the participants' scores showed deterioration, with a similar percentage showing improvement. No relevant clinical change or no change was found for 45.04% of the sample between the baseline and the first review, with only a quarter of the participants having clinical improvement during this period. Ten percent of the persons diagnosed with a common mental disorder assessed in the second review had no change or no clinically relevant change.

More of the sample (46.02%) improved in delayed memory, with the highest frequency in the clinically relevant category of improvement (29.62%) from the baseline to the first review assessment. Delayed memory continued to improve after the first review assessment.

4.4 Mood and anxiety-related symptoms

This section focuses on discussing the result according to objective two:

To determine the effect of temporary incapacity leave (3 to 24 months) on the intensity of mood and anxiety-related symptoms among persons diagnosed with common mental disorders in the Eastern Cape over time.

4.4.1 Hospital Anxiety and Depression Scale

Data were grouped based on the Hospital Anxiety and Depression Scale to indicate the percentage of persons diagnosed with a common mental disorder whose records stated the level of functioning for the various subtests in the self-report questionnaire.

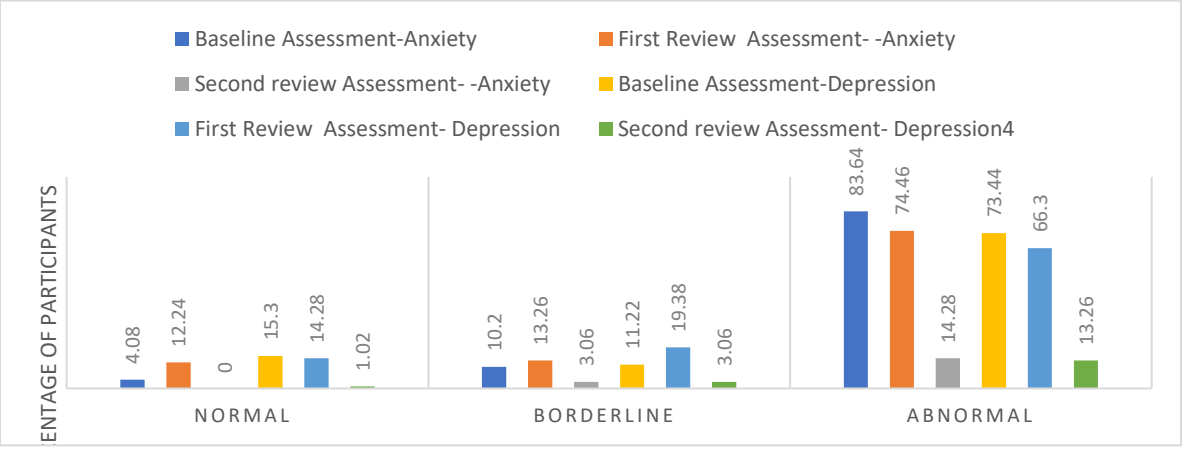


Figure 4.5. Anxiety scores on the Hospital Anxiety and Depression Scale at the time of each assessment as reflected in patient records.

The Hospital Anxiety and Depression Scale was the assessment used to measure 98 of the 162 records for mood and anxiety during the baseline, first and second review assessments.

From Figure 4.5, it can be noted that a total of 83.64% (n=82) of the sample reported abnormal levels of anxiety and 73.44% (n=72) abnormal depression at the baseline assessment, which was somewhat less at the first review, 74.46% (n=73) and 66,3% (n=65). A similar trend was noted at the 2nd review period, although the numbers were much lower.

The highest percentages fell within the two abnormal ranges, indicating that the people diagnosed with a common mental disorder self-reported that they were clinically anxious or depressed during that specific assessment. Anxiety scores within the abnormal ranges at the time of the baseline assessment reported that 73.44% of the sample were clinically anxious, and 66.3% remained clinically anxious, as indicated by scores obtained from the following review assessment. Likewise, scores on the two abnormal categories of the depression scale at the time of each evaluation followed a similar trend at baseline, 83.63%, first review, 74.45%, and second review, 14.28%.

4.4.2 Change in Scores on the Hospital Anxiety and Depression Scale at Baseline, First Review and Second Review

Changes in the Hospital Anxiety and Depression Scale scores were determined for both subtests. The minimal MCID for the Hospital Anxiety and Depression Scale is a 1-point difference in scores, so records with an increase or decrease in scores of 1 or less were classified as having a change that was not clinically relevant.

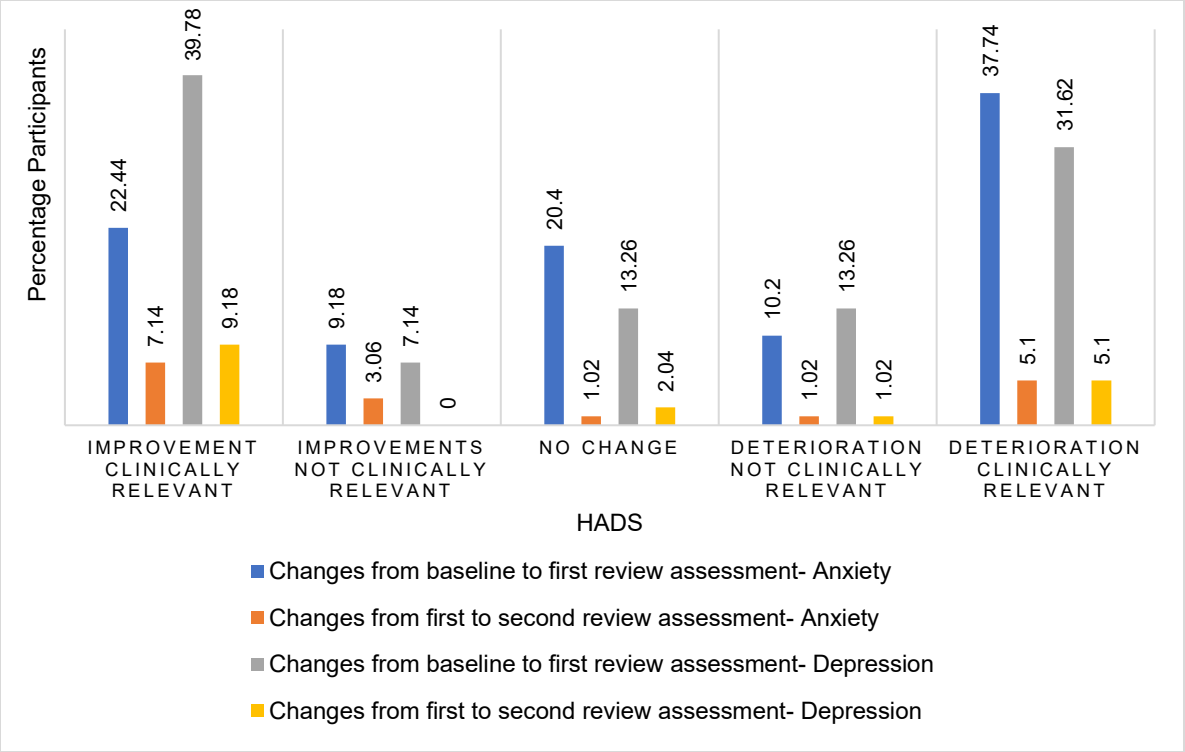


Figure 4.5 Change in anxiety scores on the Hospital Anxiety and Depression Scale reflected in various sequential client records.

A third of the records showed deterioration in anxiety symptoms (37.74%), which was clinically relevant over time. From the first to the second review, 7.14 % of the sample's scores improved with clinical relevance, and 5.10% deteriorated with clinical significance.

The mood symptoms of 39.78% of the sample improved with clinical relevance, while 31.62% decreased from the baseline assessment to the first review assessment. Data from the first and second review assessments noted a similar distribution of scores.

4.5 ZUNG Anxiety and Depression Self-Report Scale

Data were grouped based on the ZUNG to indicate the percentage of records that stated the level of functioning for the various subtests in this self-report questionnaire, as can be

seen in Figure 4.6. A total of 64 people diagnosed with common mental disorders' records utilised the Zung Self-Report Anxiety and Depression Scale to measure anxiety and depression symptoms out of the 162 in the sample.

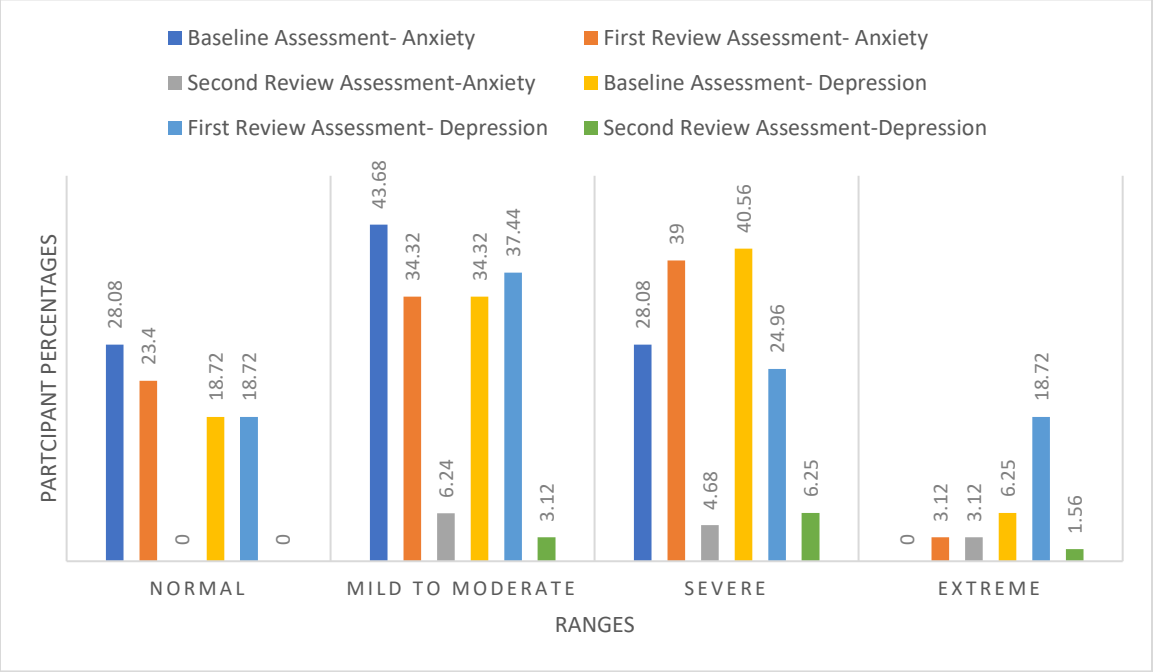


Figure 4.6 Scores during each assessment period (baseline, first and second review) of the Zung self-report Anxiety and Depression Scale.

The baseline assessment recorded that the highest percentage of the sample (43.68%) scored within mild to moderate ranges in the anxiety subtest. In the highest percentage (39.00%) within the first and second review assessments, the self-reported scores shifted to the severely anxious category.

The depression subtest of the Zung Self-Report Depression Scale indicated that 40.56% of the sample self-reported that they were severely depressed at the time of the baseline assessment. During the second review, the highest percentage, 6.25%, also scored within the severe category on this questionnaire.

The first review assessment data was equally distributed among the outer categories (18.72%, average and extreme); the highest percentage, 37.44%, moved to the mild to moderate descriptive category. Overall, the first review assessment had the highest number of/ or percentage measuring within the extreme category (n=12; 18.72%).

4.5.1 Change in Scores on the ZUNG Anxiety and Depression Self-Rating Scale's at Baseline, First Review and Second Review

Changes in the ZUNG scores were determined for both subtests, as reported in Figure 4.7. The MCID for the ZUNG is a 4.9-point difference in scores, so a person diagnosed with common mental disorders with an increase or decrease in scores of 4.9 or less was classified as having a change that was not clinically relevant.

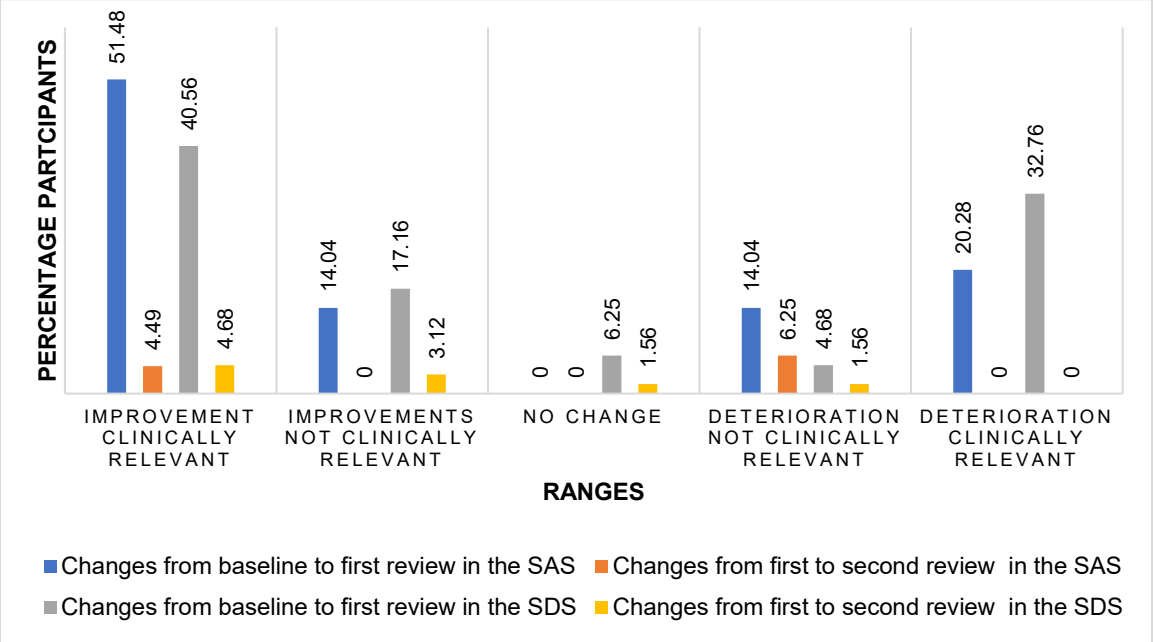


Figure 4.7 Changes that occurred during the baseline, first and second review assessments measured by the ZUNG Self-Report Anxiety and Depression Scale.

Data obtained between the baseline and first review assessments indicated that over 51.48% of the sample's self-reported anxiety symptoms improved and were clinically

significant. No changes occurred within 0% of the sample, suggesting that neither improvement nor deterioration occurred.

The Zung Self-Report Depression Scale measured equally to the Zung Self-Report Anxiety Scale, indicating a significant improvement in the self-reported intensity of mood-related symptoms from the baseline to the first review assessment.

4.6. Change in mood, anxiety and cognition on receipt of temporary or permanent incapacity leave and the impact of these changes on the sample populations' return to work.

In this section, comparative statistics and correlations were run between the Hospital Anxiety and Depression Scale and the Zung Anxiety Self-Report Scale to measure anxiety. Furthermore, scores reflected in the records between the Zung Depression Self-Report Scale as well as the Hospital Anxiety and Depression Scale's depression subtest were run. Lastly, the abovementioned data was also compared with data obtained from the Repeatable Battery for the Assessment of Neurological Status.

Comparative descriptive statistics were used to examine objective three.

> To determine the effect of change in mood, anxiety and cognition on receipt of temporary or permanent incapacity leave in a person diagnosed with a common mental disorder in the Eastern Cape.

Four of the variables measured within the moderate effect size for depression, visuospatial/ construction, attention and overall functional score (0.65, 0.62, 0.79 and 0.63) were indicative of clinical significance. However, only two of these variables, visio-spatial skills (p=0.037) and attention (p=0.000) p-values, fell within the clinically significant ranges. This indicates that the only clinical differences present were in the areas of visuospatial/ constructional skills and attention when comparing data obtained from the first and second review assessments regarding temporary and permanent incapacity leave, as depicted in Table 4.6.

Table 4.6 Comparative data of each variable from baseline to first and second review of 162 records.

Variables	Changes	Mean	Valid N	Standard Deviation	Mean	Valid N	Standard Deviation	P value	Effect size Cohen's d
		Temporary incapacity leave			Permanent Incapacity Leave				
Anxiety	1-2	2.76	62	13.03	2.93	100	10.07	0.925	0.01
	2-3	-2.00	8	4.28	-0.14	14	4.69	0.368	0.28
Depression	1-2	1.55	62	10.95	-0.87	100	10.87	0.172	0.15
	2-3	-3.33	6	2.66	-0.27	11	4.08	0.121	0.65
Immediate memory	1-2	0.95	62	17.40	1.02	100	14.11	0.978	0.00
	2-3	5.20	10	14.11	-1.52	29	22.39	0.382	0.27
Visuospatial construction	1-2	-1.89	62	13.98	0.69	100	19.24	0.361	0.11
	2-3	6.70	10	9.76	-3.57	28	13.75	0.037	0.62
Langue	1-2	2.40	62	12.06	1.46	100	16.19	0.693	0.05
	2-3	0.40	10	13.08	-3.39	28	14.85	0.480	0.18
Attention	1-2	0.55	62	17.89	0.47	100	15.88	0.977	0.00
	2-3	18.30	10	22.18	-4.18	28	12.73	0.000	0.79
Delayed memory	1-2	1.68	62	16.48	-0.27	100	18.70	0.502	0.08
	2-3	3.70	10	12.96	1.07	28	20.42	0.707	0.11
Overall functional score	1-2	2.71	62	12.80	1.42	100	14.13	0.559	0.06
	2-3	5.22	9	6.46	-2.59	27	12.09	0.074	0.63

Significance p≤ 0.05 Effect size -0.5= moderate, 0.8 = large

Table 4.7 Comparative data of each variable at the time of baseline, first and second review of 162 records.

Variable	Time	Temporary incapacity Leave			Permanent incapacity Leave			P value	Effect size Cohen's d
		Mean	Valid N	Standard Deviation	Mean	Valid N	Standard Deviation		
Anxiety	1	26.94	62	20.63	28.89	100	19.79	0.549	0.06
	2	27.82	62	21.64	31.22	100	21.72	0.334	0.10
	3	36.38	8	25.27	26.07	14	21.94	0.327	0.28
Depression	1	27.24	62	22.71	30.79	100	22.56	0.333	0.10
	2	28.15	62	22.85	30.30	100	22.73	0.559	0.06
	3	28.00	8	24.01	30.24	17	24.02	0.830	0.06
Immediate Memory	1	84.68	62	15.87	85.12	100	16.77	0.868	0.02
	2	85.63	62	19.26	86.14	100	17.46	0.862	0.02
	3	86.30	10	13.52	83.43	28	19.02	0.664	0.12
Visio-spatial/ construction	1	75.19	62	12.51	78.58	100	16.98	0.176	0.16
	2	73.31	62	13.99	79.27	100	16.56	0.019	0.27
	3	79.20	10	14.72	73.43	28	15.46	0.312	0.26
Language	1	82.82	62	13.80	83.16	100	16.83	0.895	0.02
	2	85.23	62	12.86	84.62	100	14.79	0.790	0.03
	3	86.80	10	12.60	79.04	28	16.32	0.182	0.37
Attention	1	72.18	62	13.56	76.74	100	18.42	0.094	0.20
	2	72.73	62	18.73	77.21	100	19.98	0.157	0.16
	3	82.80	10	19.40	71.46	28	24.79	0.200	0.36
Delayed Memory	1	77.97	62	20.24	80.10	100	20.40	0.518	0.07
	2	79.65	62	20.19	79.83	100	20.23	0.955	0.01
	3	86.10	10	18.56	77.26	27	20.53	0.241	0.31
Overall functional score	1	72.85	62	12.95	76.64	100	15.98	0.118	0.18
	2	75.56	62	16.13	78.06	100	17.17	0.359	0.10
	3	81.50	10	14.91	74.96	28	16.68	0.282	0.28

Significance p≤ 0.05 Effect size -0.5= moderate, 0.8 = large

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At the time of each assessment, the cognitive domain that measured clinically significant was Visio-spatial skills at time 2, with a p-value of 0.019

Comparative data from the assessments were used to examine objective four:

> To determine the effect of change in mood and cognition in terms of return to work in a person diagnosed with common mental disorders in the Eastern Cape.

Comparing the means and standard deviation between the sample as indicated in Table 4.9 of those who returned to work with those remaining on incapacity leave, clinical differences were identified within the domains of attention (p=0.000) and delayed memory (p=0.026) at Time 2-3, and 0.026 at Time 1-2.

There was a significant difference in the scores between those in the sample who returned to work and those who did not for anxiety at Time 3 (p= 0.031), and for cognition, the overall Repeatable Battery for the Assessment of Neuropsychological Status score at Time 3, (p=0.040) for immediate memory at Time 2 (p=0.041) as indicated in Table 4.8 and 4.9.

Table 4.8 Comparative data of each variable at the time of baseline, first and second review of 162 records reporting on return to work at the time of the last assessment.

	Times	Did not return after			Returned to work			P value	Effect size Cohen's d
		Mean	Valid N	Standard Deviation	Mean	Valid N	Standard Deviation		
Anxiety	1	28.27	124	19.48	25.12	33	21.48	0.421	0,10
	2	30.44	124	20.99	25.85	33	23.60	0.279	0,14
	3	24.22	18	19.53	54.33	3	28.94	0.031	0,89
Depression	1	30.05	124	22.99	24.03	33	19.78	0.172	0,18
	2	30.18	124	22.91	23.91	33	20.27	0.155	0,19
	3	29.23	22	23.96	31.67	3	24.79	0.870	0,07
Immediate Memory	1	84.42	124	16.39	86.73	33	14.82	0.465	0.10
	2	83.99	124	17.33	91.15	33	19.39	0.041	0.26
	3	**-0.43**	**124**	**14.63**	**4.42**	**33**	**14.55**	**0.092**	**0.22**
Visuo-spatial skills/ construction	1	78.35	124	16.18	73.03	33	12.59	0.082	0.24
	2	77.85	124	16.28	72.79	33	13.96	0.105	0.22
	3	**-0.50**	**124**	**18.82**	**-0.24**	**33**	**12.11**	**0.941**	**0.01**
Language	1	82.67	124	16.26	83.45	33	13.60	0.799	0.03
	2	83.94	124	14.42	86.94	33	12.88	0.280	0.14
	3	**1.27**	**124**	**15.58**	**3.48**	**33**	**10.34**	**0.442**	**0.11**
Attention	1	76.23	124	17.49	70.36	33	14.32	0.078	0.24
	2	75.10	124	19.66	74.12	33	18.81	0.797	0.03
	3	**-1.12**	**124**	**15.57**	**3.76**	**33**	**18.91**	**0.129**	**0.19**
Delayed Memory	1	79.06	124	20.41	78.58	33	19.74	0.902	0.02
	2	77.60	124	19.77	84.91	33	19.50	0.060	0.25
	3	**-1.47**	**124**	**18.30**	**6.33**	**33**	**15.32**	**0.026**	**0.50**
Overall functional score	1	75.55	124	15.60	73.06	33	12.73	0.400	0.11
	2	76.08	124	16.79	78.70	33	16.61	0.426	0.10
	3	74.03	31	15.93	89.00	6	14.21	0.040	0.65

Significance p≤ 0.05 Effect size -0.5= moderate, 0.8 = large

Table 4.9 Comparative data of each variable from baseline to first, as well as first to second review of 162 records reporting on return to work during the time of the last assessment.

Variables	Times	Did not return to work			Return to work			P value	Effect size Cohen's d
		Mean	Valid N	Standard Deviation	Mean	Valid N	Standard Deviation		
Anxiety	1-2	2.88	124	10.89	2.67	33	13.28	0.925	0,01
	2-3	-0.83	18	4.53	0.33	3	5.86	0.694	0,16
Depression	1-2	0.03	124	11.87	0.00	33	6.75	0.988	0,00
	2-3	-1.07	15	4.03	-3.50	2	0.71	0.419	0,56
Immediate memory	1-2	-0.43	124	14.63	4.42	33	14.55	0.092	0.22
	2-3	-0.56	32	21.56	4.33	6	18.04	0.605	0.16
Visuospatial construction	1-2	-0.50	124	18.82	-0.24	33	12.11	0.941	0.01
	2-3	-2.77	31	13.42	8.83	6	11.46	0.056	0.61
Langue	1-2	1.27	124	15.58	3.48	33	10.34	0.442	0.11
	2-3	-2.03	31	15.57	-5.50	6	6.53	0.598	0.18
Attention	1-2	-1.12	124	15.57	3.76	33	18.91	0.129	0.19
	2-3	-2.13	31	12.87	25.50	6	25.23	0.000	1.08
Delayed memory	1-2	-1.47	124	18.30	6.33	33	15.32	0.026	0.50
	2-3	1.16	31	19.60	8.17	6	11.37	0.405	0.28
Overall functional score	1-2	0.53	124	14.01	5.64	33	10.57	0.053	0.26
	2-3	-1.53	30	11.94	6.20	5	5.02	0.167	0.54

Significance p≤ 0.05 Effect size -0.5= moderate, 0.8 = large

Table 4.10 Correlation statistics between anxiety (Hospital Anxiety and Depression Scale and Zung Self-Report Anxiety Scale), depression (Hospital Anxiety and Depression Scale and Zung Self-Report Depression Scale), and cognition, Repeatable Battery for the Assessment of Neuropsychological Status

Variables	Time	Assessments	Correlation scores	
			Time 2	Time 3
Anxiety	Change	1-2	-0.01	-0.13
		2-3	-0.01	-0.05
Depression	Change	1-2	0.06	-0.15
		2-3	-0.06	**0.59**
Overall functional score	Change	1-2	0.06	-0.15
		2-3	-0.26	**-0.38**
Immediate Memory	Change	1-2	0.15	0.14
		2-3	**-0.39**	**-0.64**
Visuo-spatial/ constructional skills	Change	1-2	0.10	-0.17
		2-3	-0.21	0.20
Language	Change	1-2	-0.05	0.16
		2-3	-0.13	-0.07
Attention	Change	1-2	-0.02	-0.24
		2-3	-0.04	**-0.34**
Delayed Memory	Change	1-2	0.07	0.13
		2-3	**-0.36**	**-0.36**

A similar result to that for depression was found for overall cognitive function, where a moderate negative correlation indicates a decline in cognitive function associated with the length of time between assessment at Times 2 and 3.

The decline in Immediate memory and delayed memory was associated with the length of time for assessments between Time 1 and 2 as well as Time 2 and 3, indicating that the decline in these cognitive functions became worse over time from the time of the baseline assessment with the longer the incapacity period. A strong correlation was found for immediate memory for change associated with the timeframes from Time 2 to 3.

4.7 Conclusion

As per objective one, data from the RBANS was used to determine the effect temporary incapacity leave (3 to 24 months) has on cognitive functions such as memory, attention, visual-spatial skills, and language of a person diagnosed with a common mental disorder in the Eastern Cape over time.

At the time of the second review assessment, all 38 records reported the overall functional score measured to be below average on the RBANS. During the baseline assessment, 14.77% of the records reported scores within the average range. As time progressed, the changes within the cognitive domains (immediate and delayed memory, attention, visuo-spatial skills, as well as language) demonstrated a decline. Scores obtained at the time of the baseline assessment indicated that the highest measured deficit was for attention. The second was visuo-spatial/constructional abilities, and the third was immediate memory.

At the second review, a decline in immediate memory and delayed memory, as well as visuo-spatial/constructional abilities, was noted. The results reported a slight improvement at the time of this review within the domain of attention. However, at the time of the second review, greater deficits were noted within all subtests except for immediate memory.

Comparative data between the baseline, first and second reviews indicated that at the first review 28.39% of the sample improved with clinical relevance, however a higher percentage of 26.54% deteriorated but this was not with clinical relevance. Furthermore, more than half of the records reported improvement or deterioration with clinical relevance in the immediate memory subtest at the time of the first review. At the time of the second review, most of the sample's immediate memory had improved.

Consistently, the records reported performance in the visuo-spatial/constructional subtest at the time of the first and second review to have declined with clinical relevance. The language subtest indicated that at the time of the second review, 7.40% of the sample's language abilities deteriorated with clinical relevance.

Delayed Memory had the highest frequency in clinically relevant improvements at 29.62%.

Objective two was analysed using data obtained from the Hospital Anxiety and Depression Scale and Zung Anxiety and Depression Self-Report Inventory.

Data from the Hospital Anxiety and Depression Scale indicated that at the time of the baseline assessment, 83.64% and 73.44% of the sample presented with abnormal levels of anxiety and depression. A high percentage of the records reported that those assessed remained anxious at the time of the first review assessment. The depression scores followed a similar trend to the anxiety scores. Comparative data indicated that 37.37% and 31.62% of the sample deteriorated with clinical relevance in terms of anxiety and depression from baseline to the first review assessment. A slightly higher percentage of 39.78% of the sample improved with clinical relevance in the depression subtest.

The ZUNG Anxiety and Depression Self-Report Scale indicated that 40.56% of the sample reported being severely depressed at the time of the baseline assessment, and 43.68% were mildly anxious. The highest percentage (39.00%) of scores during the first and second review assessments in the anxiety subtest shifted to the severe range. During the second review assessment, the highest percentage remained within the severe range. Comparative data obtained from the three assessments indicated that 51.48% of the records show that anxiety improved with clinical significance. Depression scores similarly improved with clinical significance.

Objective three found that the only clinical differences were present within the cognitive domains of visio-spatial/constructional skills and attention when comparing data at the time of the first and second reviews.

Lastly, data obtained from all the assessments were used to analyse the last objective by comparing the means and standard deviation between the sample of those who returned to work with those remaining on incapacity leave found clinical differences were identified within the domains of attention and delayed memory.

The data indicated that changes occurred within specific mental functions. The cognitive domains mostly affected were attention and visuo-spatial. Memory to a lesser extent. Deterioration with clinical relevance was also established in terms of anxiety and depression.

CHAPTER 5: DISCUSSION

5.1 Introduction

This chapter discusses the results of the analysis of the collected retrospective data as reported in Chapter 4 in relation to current literature. The chapter is organised to first discuss the demographics of the research sample of records, followed by a discussion of the results as per the five research objectives determined for this study. The limitations of this study were also included in this chapter.

5.2 The research sample

The sample consisted of 162 records of clients assessed for incapacity leave who met the set inclusion criteria. The sample size calculation indicated that 132 records needed to be reviewed for a result that met a 95% confidence level and a 5% margin of error. The 162 records reviewed exceeded this number by 30 records. This allowed for sufficient data to be statistically examined to describe with some certainty the characteristics of the sample of mental health care users referred to the research site to determine if incapacity is required or not following a common mental disorder. The size of the sample allowed for some examination of the performance of those assessed on the routine assessments used over time as well as some of the characteristics that may predict a return to work or the need for longer incapacity leave (Serdar et al., 2020).

5.2.1 Demographics of sample

The demographic information collected was limited.

5.2.2.1 Age and gender

The 162 records reported that most people diagnosed with common mental disorders assessed for temporary incapacity leave were in the two age bands from the middle and towards the end of the working age bands (40-60 years; 76.8% of the sample). A study conducted by Bufano et al. (2024) found that a high-pressure work environment leads to a decline in normal cognitive functioning, and ageing can be a precursor for cognitive impairments. A study conducted by Ramsammy (2019) found that amongst healthcare practitioners in Gauteng, a Province of South Africa, the profession with

the highest percentage of individuals on temporary incapacity leave were nurses and more than a third were 45 years old and older. Findings from Ramsammy's (2019) study are similar to the age band identified in Table 4.1.

There were more male persons diagnosed with common mental disorders (57.2%) than females in this study. This finding is contrary to most literature indicating that the prevalence of common mental disorders is reported to be generally higher among women than men. The prevalence of women diagnosed with a common disorder is estimated to be one in every five women (Azharuddin et al., 2023), and women have a higher tendency to be diagnosed with depression and anxiety disorder (Azharuddin et al., 2023). The reason for the higher percentage of males in this study is likely due to a higher percentage of male records reviewed within this study; a total of 93 out of 162 were males. Perhaps due to the practice's contract with the Department of Correctional Services and also within the South African population, more men are employed than women. The employment ratio of 64.9% men and 54.3% women being employed within the South African context may explain why there were more males included in the sample than females (Department: Statistics South Africa, 2023).

The language was not extracted from the records, but in retrospect, this information may have been valuable to examine if language influenced some of the domain scores, such as language in the Repeatable Battery for the Assessment of Neuropsychological Status. All three data collection tools were developed and presented in English. Although the therapist in charge of the case may have been fluent in the language of the person being assessed and been able to assist with any language difficulties, the Repeatable Battery for the Assessment of Neuropsychological Status and the other two tools are self-report and therefore, language assistance may have been less obvious.

5.2.2.2 Medical and Occupational Information

Most records indicated that persons diagnosed with a common mental disorder referred for temporary incapacity assessment were diagnosed with medical health conditions where a mood dysfunction was the most common feature (Major depressive disorder 42.44% and bipolar disorders 31.27%). This is consistent with the literature, as in 2019, it was reported that approximately 12.78% of the South African workforce

has a mental disorder, and one in four employees suffers from an anxiety or mood disorder (De Jesus et al., 2024). An earlier study by Stander et al. (2016) also found that one in every four employees within the open labour market of South Africa had been diagnosed with depression and found that these employees, during their last episode of depression, took approximately 18 days of sick leave. There has also been growing evidence suggesting that one of the most significant functioning-impairing components of depression within the workforce is cognitive impairments influencing work performance (Stander et al., 2016).

Almost a quarter of the records indicated that a person diagnosed with a common mental disorder had post-traumatic stress disorder. This is higher than the national estimate of 15.85 and well above the global 3.9% average. South Africa is one of the countries with the highest prevalence of violent crimes in the world, caused by robbery, gender-based violence, sexual assaults, murders, etc. The South African population, due to the high violent crime rate, has a higher exposure to violence, resulting in a higher prevalence of post-traumatic stress disorder (Africamindsmatter.org, 2024).

More than a quarter (n=43; 26.44%) of the sample were correctional officers, and 11 (6.74%) were policemen (Bezzerra et al., 2016; Irwin et al., 2022). The high number of correctional services in the sample is reflective of the fact that the research site is a private practice which has a service contract with the Department of Correctional Services. The majority of the correctional officers assessed and treated by the occupational therapy practice work in a maximum-security prison well known for gang violence. Correctional officers are known to be exposed to violence daily and often sustain injuries on duty as a result of prison violence (Veleon, 2022).

It is interesting to note that no record indicated that a diagnosis of substance abuse disorder when substance abuse is reported to be high in the correctional service and police literature and the national average is reported to be 13.3% which is much higher than the global average of 5% (Jayawardene et al., 2024). Due to stigmatisation, it is an internal practice policy amongst occupational therapists not to record substance use disorders to protect the client’s privacy

The records indicated that most people diagnosed with a common mental disorder had been awarded permanent incapacity leave, indicating a more permanent disability rather than a psychosocial temporary disability. This is supported by a study conducted

by Talatala et al. (2020), who reported that inadequate management of mental illness leads to a higher disability rate among people diagnosed with a common mental disorder within South Africa. Cognitive decline is seen as an independent risk factor towards the development of permanent psychosocial disability (Zeng et al., 2023). Cognitive impairments associated with common mental disorders could account for the reduced return to work rate (20.30%) of the sample.

A high percentage of the sample (n=153; 94.10%) were referred for outpatient occupational therapy sessions after the baseline assessment; however, only (n=11;6.82%) of the sample attended. Within the insurance industry, the insurer will fund occupational therapy sessions if the clients are suitable candidates for vocational rehabilitation. The occupational therapists employed by the practice send motivations and quotes for proposed treatment sessions as well as develop a specialized treatment plan based on assessment results. However, these benefits are approved on a case-by-case basis, and not all insurance companies pay for treatment. It is up to the case manager employed by the company to approve these benefits. It is unclear what criteria are used by case managers to grant or refuse this additional funding. Concern has been expressed by the occupational therapy profession that few case managers are occupational therapists who would understand the benefits of early return to work and vocational rehabilitation, most case managers are from the nursing profession who may not be able to make a considered decision of value vocation rehabilitation and there is insufficient research that provided for the efficacy of this intervention with this cohort of patients..

5.2.2.3 Timing of Assessments

All 162 records reported the referral for the baseline assessment at 0 months with a first review mostly between 3 and 12 months. Only 33 people diagnosed with common mental disorders were referred for a second review, which mostly occurred between 13 and 24 months. The stipulated time frame for the review dates is every six months, however, the case managers employed by the insurance companies have the authority to change the review times. Furthermore, some of the government departments have an internal incapacity leave policy (including nurses, teachers, police officers and correctional officers, of which 52.08%, n=84 of the sample consist of) and do not always follow the recommended timeline (Government of South Africa, 2021).

5.3. The effect of temporary incapacity leaves on cognitive functioning as measured by Repeatable Battery for the Assessment of Neuropsychological Status

This section of the discussion focuses on the first of the study objectives:

> To determine the effect temporary incapacity leave (3 to 24 months) has on cognitive functions such as memory, attention, visual-spatial skills, and language of a person diagnosed with a common mental disorder in the Eastern Cape over time.

5.3.1 Overall functional scores over the three time periods

The analysis of records reviewed showed that the overall scores on the Repeatable Battery for the Assessment of Neuropsychological Status showed that no person diagnosed with a common mental disorder achieved the high average or superior range of scores on any of the three assessment periods. The scores on the baseline (n=162) and first assessment (n=162) were quite similar in that they varied across the four lowest descriptive categories, with the highest number scoring in the extremely low descriptive category (baseline=33.96% and time 1=34.44%). At the first review, although slightly higher scores fell into the average (14.77%; n=23) and above-average descriptive categories, a slightly higher percentage scored (n=52; 33.98%) in the extremely low descriptive category range. At the second review, the scores of all remaining persons diagnosed with common mental disorders (n=22) fell into the three lowest descriptive categories (extremely low, borderline and low average), which indicated an overall decline in the scores from the baseline assessment to the second review.

This finding is consistent with a systematic review by Rock et al. (2014), who reported that literature suggests that cognitive dysfunction is a common feature in approximately two-thirds of patients diagnosed with depression and has been associated with poor treatment outcomes, especially concerning work. It has also been noted that functional cognitive deficits may be persistent after the mood features have subsided and increase in severity with additional episodes (Rock et al., 2014; Atique-Ur-Rehman et al., 2019). A study conducted by Seeberg et al. (2018) found similar results, indicating that 95% of people diagnosed with major depressive disorder

experience global cognitive decline or impairments. Interestingly, the study also found that 50-70% of the 95% of people diagnosed with major depressive disorder have residual cognitive fallout during the remission phase of the illness (Seeberg et al., 2018). While most literature describes mild to moderate disability in overall cognitive function associated with common mental disorders, severe cognitive dysfunction has been described as more consistently associated with dementia and evident in persons over 70 years of age which was not relevant in this current study as all records indicated ages under 65 years (Knopman et al., 2015).

Literature has also suggested that cognitive deficits associated with depression in older adults may be associated with early signs of dementia and are a concern in all persons diagnosed with a common mental disorder over the age of 60 (Peterson, 2016). Although only 2 records reviewed in this current study included persons in this age group, 53 (32.6) fell into the 51-60 age band. Although no precise age of onset has been determined, a younger age of onset has been identified in several studies in Africa and South America (Hendriks et al., 2023).

The international working group on mild cognitive impairments has also suggested that work stress and burnout may play a role in the persistence of cognitive disorders associated with depression (Deligkaris et al., 2014). Cognitive deficits have also been reported as a feature of post-traumatic stress disorder, which falls into the common mental disorders group of conditions (Jackson et al., 2014). Thus, the role of stress, especially work stress, should also be considered when evaluating these persons diagnosed with a common mental disorder for incapacity leave.

Knight et al. (2018) reported that while cognitive deficits are found in persons diagnosed with common mental disorders are reported in literature, there has been insufficient research on the specific nature and measurement of these deficits to fully understand the long-term implications and best practice for the intervention of these cognitive deficits. It is postulated by Ahern et al., 2024, that targeted specialised early cognitive interventions may greatly assist in enhancing and promoting the prognosis of recovery of the person diagnosed with a common mental disorder.

5.3.1 Results of Subtests of the Repeatable Battery for the Assessment of Neurological Status

5.3.1.1 Immediate and Delayed Memory

The highest scores at all assessment times are in the average range (62.68%), with a slight increase in the extremely low category over time as measured in the immediate memory subtest.

The fact that memory was found to be affected in this study was not unexpected. Research has suggested that memory deficits found in psychiatric conditions are typical. Common mental disorders are reported to mainly affect immediate or working memory, which is the ability to temporarily retain and manipulate information as needed while completing a task (Kushawha, 2024) and are caused by the primary mental condition or some intervention methods, such as electroconvulsive therapy (Kushawha, 2024). When taking information obtained from Figure 4.2 into consideration at the time of the baseline and first review assessment, 33.83% of the sample scored within the extremely low descriptive category. There is limited literature about the impact of common mental disorders causing a decline in delayed memory.

A study conducted by Akhouri et al. (2014) found that immediate memory is adversely affected equally by anxiety and depression. Furthermore, this study found that delayed memory (remote) remained intact or unaffected by common mental disorders (anxiety and depression) (Akhouri et al., 2014). Of the 162 client records reviewed, 42.44% of the sample presented with deficits (scoring within extremely low and borderline ranges) in delayed memory at baseline assessment. A total of 52.94% of the sample performed within average ranges (low average to average), 4.31% in high average ranges, and 57.25% overall scored within average ranges (low average to high average). At the time of the first review, 46.13% of the participants scored below average ranges (extremely low and borderline ranges) and 53.50% low average to high average ranges. During the third review assessment, 11.71% scored within the lowest ranges. Post-traumatic stress disorder has been linked to memory deficits. It is speculated to be a result of high levels of stress hormones and a poorer modern-day evolutionary adaption towards the primal human stress response (Rigoli et al., 2016).

Memory impairments cause a decline in the person diagnosed with a common mental disorder's ability to recall, code and store information. Memory difficulties have been linked to poor effective and efficient performance of work tasks, resulting in reduced productivity (Pickett, 2024). A study by Uribe et al. (2017) found that presenteeism at work when experiencing cognitive decline amongst individuals diagnosed with depression can be more costly to the employer than absenteeism due to the reduced work speed of the employees.

5.3.1.2 Visio-spatial skills

Visio-spatial scores are perhaps the most surprising, with only 39.98% in the low and average ranges. However, the highest prevalence of scores at the time of all three assessments scored within the extremely low descriptive category (38.75%, 41.96% and 12.3%). At the time of baseline assessment, 55.97% scored within the lowest ranges, which increased at the time of the first review to 60.10% having a deficit within this subsection.

A study conducted by Nelson et al. (2015) investigated the impact of depression on visio-spatial skills and mathematic abilities and found that depression results in some visio-spatial decline as the depressive illness adversely affects the parietal cortex of the brain, which plays a vital role in visuospatial abilities. The impact of anxiety on this cognitive domain is less understood. However, the study by Nelson et al. (2015) found that a co-morbidity of depression and anxiety was associated with visuospatial processing difficulties. A link has been identified between visual-spatial working memory difficulties and bipolar mood disorder (Gallagher et al., 2014). Visual-spatial working memory is the ability to process an object's identity and spatial location to perform a task. Visio-spatial processing difficulties identified within the sample population could result from both visio-spatial processing difficulties and visual-spatial memory deficits (Gallagher et al., 2014).

Visio-spatial impairments have been linked to the long-term use of cannabis in non-independent adolescents (substance use) and are associated with poor academic performance (Goycolea et al., 2021). This link could not be determined in the current study as substance abuse was not recorded in any record as a practice policy.

As indicated by literature (Fernandes et al., 2018; Goycolea et al., 2021; Nelson et al., 2015) Common mental disorders such as depression, bipolar mood disorder and substance use disorder, as well as to a lesser extent anxiety negatively impact on visuospatial skills, which is consistent with scores obtained in the Repeatable Battery for the Assessment of Neuropsychological Status.

5.3.1.3 Attention

At the time of the baseline, first and second review assessment, 33.83%, 36.9% and 9.23% of persons diagnosed with a common mental disorder had the highest score in the extremely low descriptive category. At the time of each assessment, the majority (baseline 84.26%, first review 73.18%, second review 15.38%) of the sample population scored in the below-average ranges. A slight shift of 11.08% of the sample scored higher in the first review assessment when compared to the baseline scoring in average ranges.

Attention deficits associated with common mental disorders have been well-recorded in literature and have a significant impact on day-to-day functioning (Pike et al., 2020; Wang et al., 2020). Approximately a quarter of the records indicated that the mental health care users assessed suffered from post-traumatic stress disorder. This condition specifically causes alterations in attention due to hypervigilance. These attentional alterations are known as threat bias and are a common occurrence associated with this diagnosis (Ely et al., 2023).

5.3.1.4 Language

The recorded sample scored the highest within the subtest of language, scoring the highest (66.42%) within the low-average and high-average groups at the time of the baseline assessment. There was a slight improvement in language scores at the time of the first review assessment, then a mild decline occurred in scores at the time of the second review assessment.

Common mental disorders do not directly impact language abilities. The Repeatable Battery for the Assessment of Neuropsychological Status was initially developed to measure neurocognitive decline due to dementia and was not initially designed for but later validated to be used to assess the cognition of individuals diagnosed with a

common mental disorder (Randolph et al., 1998; Pearson Assessments, 2025). As indicated by literature, language impairments are not often associated with common mental disorders (Trivedi, 2006).

However, cognitive deficits in attention, immediate memory, executive functioning and cognitive processing could lead to difficulty in encoding and retrieving linguistic information (Trivedi, 2006).

South Africa has 12 official languages, of which English is the universal language spoken within the business world. The test questions of all three data collection tools are presented in English (Petty, 2024). While language was not a demographic variable that was collected, some of the sample's first language may not have been English, which could account for the slightly lower scores. However, the majority of the scores attained were within average ranges, indicative of mild to no impairments within this domain.

5.4 To determine the effect of temporary incapacity leave on anxiety and depression symptoms as per objective two.

> To determine the effect of temporary incapacity leave (3 to 24 months) on the intensity of mood and anxiety-related symptoms among persons diagnosed with common mental disorders in the Eastern Cape over time.

Data obtained from the Hospital Anxiety and Depression Scale and Zung Self-report Anxiety and Depression Scale were used to discuss the second and third objectives:

Throughout all three assessment times, baseline, first, and second review, the highest percentages, 73.44%, 66.30%, and 13.26% on the depression scale and 83.64%, 74.46%, and 14.28% on the anxiety scale within the sample measured within abnormal ranges—most of these scores improved from baseline to first review assessment by 39.78% with clinical relevance. Despite improving, the participant's scores remain within abnormal ranges.

A study conducted by Rostam (2020) found that individuals struggling with anxiety experience anxiety for approximately 40% of their day. This study views work stress as one of the main contributing factors towards the experience of anxiety. Extraction from the workplace limits exposure to work-related stressors and could be the reason

for mild improvements in the experience of anxiety and depression symptoms as recorded by the Hospital Anxiety and Depression Scale from baseline to first review assessment.

Work forms part of identity development as well as meaningful engagement within occupations, promoting intrinsic motivation (Waller, 2020). Additionally, work provides the employee with a sense of belonging and meaningful social interaction and nurtures authenticity (Sandoghdar et al., 2023). The researcher postulated that a lack of work engagement prevents the person diagnosed with a common mental disorder from benefiting from the positive aspects of work, resulting in a loss of a work identity as well as meaningful social engagement, resulting in isolation. The person-environment relationship (Ranka et al., 2011) is a multilayered and complex problem. When assessing clients with a common mental disorder, it is important to consider the various personal and environmental factors to allow for a more comprehensive assessment to identify the exact problem. The occupational therapist should take into consideration the person and environment interrelationship when recommending temporary incapacity leave as well as continuation of incapacity leave.

Social withdrawal or isolation is a core symptom of common mental disorders. Social isolation is an adaptive response or protective response. However, if it is excessively used for a prolonged period, it becomes a maladaptive response resulting in an avoidant behaviour (Ike et al., 2020). An example often reported by the patients diagnosed with a common mental disorder within the clinical field the researcher works in is avoiding going to shops during busy times. Another example is experiencing intense and overwhelming levels of anxiety if the working environment has several employees working within the same physical space, such as an open plan office, factory or public service environment, i.e. working at the post office. Social withdrawal may pose a substantial barrier towards the return-to-work prospects and should be taken into consideration when considering a return to work.

Avolition or a lack of motivation is a characteristic symptom of depression and is linked to a decline in task initiation and completion and may lead to a higher tendency to procrastinate (De Rosse et al., 2019). Avolition/ reduced motivation and poorer work performance are consistent with the findings conducted by the study of Uribe et al. (2017), indicating that presenteeism is of great concern amongst individuals

diagnosed with a common mental disorder. These individuals may remain unproductive within the workplace even when present at work.

The Zung Self-Report Anxiety Scale and Zung self-report depression Scale indicated that 51.48% of the sample improved with clinical relevance. The Zung Self-Report Anxiety Scale and Zung self-report depression Scale reported the opposite of the Hospital Anxiety and Depression Scale, indicating that the client's anxiety and depression symptoms improved during the incapacity period.

The reason for the discrepancy in the Zung Self-Report Anxiety Scale, Zung self-report depression Scale, and Hospital Anxiety and Depression Scale scores could be that the Hospital Anxiety and Depression Scale measures general anxiety and mood symptoms and is not related to psychiatric conditions, whereas the Zung Self-Report Anxiety Scale and Zung Self-Report Depression Scale were designed to measure psychological disorders. Additionally, test sensitivity can cause a discrepancy in scores. Another factor to consider is that the Zung was developed more than 50 years ago before the introduction of the Diagnostic Statistical Manual of Mental Disorders 3rd edition (Sephry, 2014) but despite the age of this questionnaire, it remains a valid screening tool for mood and anxiety-related symptoms (Dunstan et al., 2017).

When using self-report questionnaires, there are always advantages and disadvantages. Social desirability bias is a concern when using self-report questionnaires as the response may be invalid based on the individual need to be liked or respond in a socially appropriate manner (Demetriou et al., 2015). An additional limitation of self-report questionnaires amongst this specific sample is the financial benefits from insurers. The financial incentive may cause a misrepresentation of responses.

5.5. Changes in mood, anxiety and cognition on receipt of temporary or permanent incapacity leave and the impact of these changes on the sample populations' return to work.

Data were obtained from the Hospital Anxiety and Depression Scale, Zung Self-Report Anxiety and Depression Scale, and the Repeatable Battery for the Assessment of Neuropsychological Status to discuss objectives three and four.

Objective three was to determine the effect of change in mood, anxiety and cognition on receipt of temporary or permanent incapacity leave in a person diagnosed with a common mental disorder in the Eastern Cape.

Objective four was to determine the effect of change in mood, anxiety and cognition in terms of return to work in person diagnosed with a common mental disorder diagnosed with a common mental disorder in the Eastern Cape.

The effect sizes indicate important clinical differences and are not dependent on sample size. An effect size of >0.05 and >0.8 equals a moderate and large effect size and a clinical difference. A p-value equal to and/or smaller than 0.05 is viewed as clinically relevant. The only clinical differences found were in the areas of visuospatial/ constructional skills (p=0.037, effect size= 0.62) and attention (p=0.000, effect size 0.79) when comparing data obtained from the first and second review assessments regarding temporary and permanent incapacity leave as depicted in Table 4.6. The cognitive domains of attention and visio-spatial skills declined with clinical significance throughout the incapacity leave.

The same ratio for the effect sizes and p-value was used to interpret the data in Tables 4.8 and 4.9. The mean and standard deviation reflected in the records of those who did return to work and the ones who did not return to work were used to determine the effect size as well as the p-value when comparing client scores of all variables. Clinical differences were identified within the following cognitive domains: attention (p=0.000, effect size 1.08 at the time of the second and third review assessments) and delayed memory (p=0.026, effect size 0.50, at the time of the baseline and first review assessment). There was a significant difference in the scores between those in the sample who returned to work and those who did not for anxiety at the second review assessment (p= 0.031, effect size 0.89). For cognition, the overall Repeatable Battery for the Assessment of Neuropsychological Status score at the time of the second review assessment (p=0.040, effect size 0.65), and immediate memory during the first review assessment (p=0.041, effect size 0.22).

To determine the effect of time on the change in anxiety, depression and cognitive function of the person diagnosed with a common mental disorder in the sample a correlation between the change in the scores on the Hospital Anxiety and Depression Scale and Zung Self-Rating Anxiety Scale and the Repeatable Battery for the

Assessment of Neuropsychological Status and the number of months between the assessments was used. Correlation scores and meaning of scores were interpreted based on the ranges below: to 0.8: Very strong positive correlation, 0.7 to 0.6: Strong positive correlation, 0.5 to 0.4: Moderate positive correlation, 0.3 to 0.2: Weak positive correlation, 0.1 to 0.0: Very weak positive correlation, 0.0: No correlation. The negative weak correlation reported in Table 4.10 indicated that the change in anxiety was not associated with the length of time between assessments. A similar result was found for depression when the change between baseline assessments and assessments at baseline was considered. However, the moderate positive correlation indicates that the change in depression was associated with the length of time on incapacity leave between the first and the second review assessment.

Work is a central occupation of an adult's life and can be a facilitating or hindering factor towards the maintenance of functional cognition and healthy cognition (Mardon et al., 2021; Sandoghdar et al., 2023; Waller, 2020; Bufano et al., 2024). Active engagement within the occupational area of work can stimulate, promote and maintain a functional level of cognition (Bufano et al., 2024). Contrary a lack of work can have the opposite effect. The longer the period of absence, the worse the vocational prognosis. Long-term sickness absence is equally impacted by health-related concerns and symptoms. Non-health-related factors such as receiving insurance benefits and a negative perspective of the working environment are viewed as barriers towards return to work (Weerdesteijn et al., 2020). The success of reintegrating individuals who are recipients of temporary incapacity leave is early intervention and return to work. It was found that the success of the reintegration process is directly related to the buy-in from the person diagnosed with a common mental disorder and the interplay between the insurer and the treating occupational therapist (Noteboom et al., 2024).

5.6 Conclusion

The conclusion will discuss the pertinent findings relevant to the objectives.

Data obtained from the RBANS found that a gradual decline in the overall functional score occurred from the baseline to the review assessment. The cognitive domains that were mainly impacted, as indicated by statistical analysis, were attention and visuospatial skills. The domain of memory was impacted to a lesser extent; however, cognitive impairments were identified within these domains. Language was least impacted, as reported by the Repeatable Battery for the Assessment of Neuropsychological Status. Triangulated consistency was achieved via correlation statistics indicating that visuospatial/ constructional skills ($p=0.037$, effect size= 0.62) and attention ($p=0.000$, effect size 0.79) declined with clinical relevance.

The Hospital Anxiety and Depression scale indicated that anxiety and depression scores remained within abnormal ranges at all three assessment times, despite (39.78%) of the sample's scores improving with clinical relevance. The Zung Self-Report Anxiety and Depression Scale reported contradictory evidence indicating that both anxiety and depression improved during the incapacity period. The negative weak correlation found that anxiety and depression symptoms were unrelated to the times of the assessment. A moderate positive correlation indicates that the change in depression was associated with the length of time on incapacity leave between the first and the second review assessment.

CHAPTER 6: CONCLUSION & RECOMMENDATIONS

6.1 Introduction

Chapter 6 aims to answer the research question about the findings discussed in Chapter 5. The research questions are as follows: What mental functions should be taken into consideration when recommending temporary incapacity leave to prevent permanent psychosocial disability from occurring?

6.2 Main findings in answering the research question

More than two-thirds (n+125, 76.26%) of the sample did not return to work after temporary incapacity was initiated. Furthermore, out of the 162 records, 100 (61.50% of the sample) were placed on permanent incapacity leave, indicating that the multidisciplinary team (psychiatrist, occupational therapist and/or psychologist) found the person diagnosed with a common mental disorder to have sufficiently severe symptoms to cause permanent psychosocial disability. A very limited number of records indicated that the mental health care users attended the recommended Vocational rehabilitation program planned to facilitate a return to work for mainly financial reasons.

It was found that the cognitive domains of the persons diagnosed with a common mental disorder in the sample declined with clinical relevance during the incapacity period are visuospatial/ constructional skills ($p=0.037$, effect size= 0.62) and attention ($p=0.000$, effect size 0.79). A gradual decline in the overall functional score was also established from the baseline to the second review date.

The aspects of anxiety and depression reported a negative weak correlation between anxiety and depression symptoms unrelated to the times of the assessment. Additionally, a moderate positive correlation indicated that the change in depression was associated with the length of time on incapacity leave between the first and the second review assessment.

When recommending temporary incapacity or extending incapacity leave based on the statistical data obtained from the study, the mental functions such as attention and visuospatial/ constructional skills should be closely monitored as within the sample, these cognitive domains declined significantly during the incapacity period.

Furthermore, the occupational therapist should consider including attention and visuospatial/ constructional skills as aspects to be addressed in therapy when developing both an inpatient and a vocational rehabilitation program.

From a holistic point of view, additional factors to consider when recommending temporary incapacity leave are the work environment, age of the person diagnosed with a common mental disorder, profession, stress, decline in attention as well as visio-spatial skills, and lastly, the adverse effects of a loss of work identify on the experience of mood and anxiety symptoms.

6.3 Reflection on the Research Process

The researcher set out to investigate the relationship between temporary incapacity leave and the impact thereof on mental functions. This section reflects the research process.

This study was a retrospective record review of 162 client records electronically stored at an outpatient occupational therapy practice. While conducting the literature review, it was well established that common mental disorders are linked to cognitive decline. However, the cause of cognitive decline amongst common mental disorders is poorly understood. Little research has been done on incapacity leave and its use amongst individuals diagnosed with common mental disorders. Whilst engaging with the literature, it was found that a multitude of factors influence the individual diagnosed with a common mental disorder's ability to cope and function within the occupation of work. These factors include the work environment, feeling supported, and managerial styles of the individual supervisor, as well as the fit of the person's skills to the specific job.

Reviewing literature throughout the research process, the researcher has grown as an occupational therapist and utilized more evidence-based practices in line with the field of occupational therapy when assessing and treating clients. A greater focus is given to the relationship between the person and the environment, which is reflective of the Occupational Performance Model (Australia).

6.4 Limitations of the study

The disadvantage of this record review was potential inconsistencies in how the data was gathered and interpreted in the assessment process and recorded in the occupational therapy record, which may have led to inconsistent test results despite some interrater reliability measures being put in place. Training and standardisation of the administration and scoring of the Repeatable Battery for the Assessment of Neuropsychological Status, as per the manual, aimed to limit recording errors.

Poor record keeping, leading to incomplete records, resulted in some incomplete records being excluded from the study. Records may also have been missed as they were stored incorrectly or were missing. Lastly, inconsistency within the periods between the baseline and review assessments was present within the research data set due to the client's not attending sessions as scheduled, as well as the referral source (treating psychiatrists) not referring the client when needed, and the referral also not being based on a set time frame. To limit the negative impact of the above-mentioned, only records that fall within a two-year period when temporary incapacity leave was initiated were included in the study. Additionally, the study exclusion criteria aimed to decrease the influence of other factors which may impact specific mental functions, such as relapse and comorbid conditions. Incomplete records were also excluded from the sample of records used to limit potential bias and data collection errors.

Limitations of self-report questionnaires may have been a limiting factor, as the participants might have provided invalid answers due to a lack of understanding of the question content, or, where sensitive questions are asked, an incorrect response may have been given. This phenomenon is referred to as social desirability bias. Participants may answer questions based on social norms rather than their answers being a true reflection of their illness experience, and the motive to not return to work but continue to be paid can also not be excluded, referring towards secondary gain. This phenomenon could lead to under- or over-reporting of symptoms, which may negatively impact the validity of the scores obtained from the self-report. However, symptoms associated with mental conditions are often based on the client's subjective experience of symptoms and cannot be tangibly measured. For this reason, self-report questionnaires are commonly used in conjunction with clinical judgement of mental

health professionals in the treatment of mental health care users (Demetriou et al.,2015). Lastly, self-report questionnaires reflect the client's illness perception, which may not be a true reflection of the client's clinical presentation (Demetriou et al.,2015).

Another limiting factor of this study is that the main focus of the study was on client factors, which excludes the role environmental factors play during incapacity leave. Environmental factors play a crucial role in maintaining mental well-being. However, the record provided limited information regarding the impact of environmental factors on the client and, for this reason, could not be included in the study. The study focused on the person rather than the interaction between the person and the environment. Inclusion of environmental factors could have broadened the argument posed by this study and gained a better understanding of the role environmental factors play in the return-to-work process.

Additionally, functional assessments (assessments developed to determine if the person diagnosed with a common mental disorder can function within the occupation of work despite their symptoms) were not recorded in the records. Due to a lack of functional assessments that can be quantified, the study cannot comment on the functional capacity of the sample during the incapacity period. Functional assessments would have provided the study with more robust information regarding each client's functional capacity at each assessment. Furthermore, confounding factors such as education, socioeconomic factors were not recorded in the records, and the impact of these factors on the specific mental functions could not be thoroughly explored. Lastly, the sample size declined during the third assessment period. The most significant changes in symptoms occurred during this period, as indicated by the data obtained from the results. Lastly, due to the internal policy of not recording substance use, no inferences could have been made regarding this diagnosis.

6.5 Recommendation for future studies based on the research findings.

The relationship between the person as a worker and the work environment is complex and interrelated. This study mainly focused on the person (client factors), gaining a better understanding of the impact of temporary incapacity leave on mental functions. However, additional factors to consider are the relationship between the person, the

specific job and the environment. Further research is needed to determine the effect of environmental factors, such as supervisors' managerial styles, support systems (both at work and home), and stress (both work-related and personal) influence the person diagnosed with common mental disorders' ability to return to their nominated position or the open labour market.

The majority (n-153, 94.10%) of the sample were advised to consult with the assessing occupational therapist to undergo vocational rehabilitation. However, only 11 of the sample attended occupational therapy sessions. Understanding the reason for poor compliance with occupational therapy services may greatly assist in filling the gap, as occupational therapists specialize in treating functional barriers towards occupational engagement and performance. Funding of vocational rehabilitative services poses a significant barrier towards engagement within these programs. As an occupational therapist, it is of the utmost importance to advocate for funding from the various stakeholders for vocational rehabilitative evidence-based services to increase the accessibility of these interventions to the South African Labour force. Lastly, to better understand the role and benefits of occupational therapy in treating persons diagnosed with a common mental disorder, it is advised that future research be done on exploring the return-to-work ratio between persons diagnosed with a common mental disorder on temporary incapacity leave that completed a vocational rehabilitation program conducted by an occupational therapist and once that did not.

REFERENCE LIST

Africamindsmatter.org. (2024). *PTSD in South Africa: A Comparative Analysis of Mental Health Challenges*. Retrieved February 20, 2025, from https://africamindsmatter.org/ptsd-in-south-africa-a-comparative-analysis-of-mentalhealth-challenges.

Ahern, E., White, J., & Slattery, E. (2024). Change in Cognitive Function over the Course of Major Depressive Disorder: A Systematic Review and Meta-analysis. *Neuropsychology Review* (10).

Akhouri, D., Javed, S., Ansari, S., Azmi, S., & Siddiqui, A. (2014). Assessment of Immediate, Recent and Remote Memory of Patients with Depression and Anxiety Disorder. *Delhi Psychiatry Journal, 17*(2), 26-30.

American Occupational Therapy Association. (2020). Occupational Therapy Practice Framework: Domain and Process (hereinafter referred to as the OTPF–4). *The American Journal of Occupational Therapy*, 1-88.

American Psychiatric Association. (2022). *Diagnostical Statistical Manual of Mental Disorders* (5th ed.). Washington: American Psychiatric Association.

Anadkar, K., & Joshi, M. (2023). A Comprehensive Literature Review on Understanding Job Burnout: Causes, Consequences, and Prevention Strategies. *International Journal of Interdisciplinary Organizational Studies*, 18(1) 1278- 1295.

Andersson , H., Sutton, D., Bejerholm , U., & Argentzell, E. (2020). Experiences of sensory input in daily occupations for people with serious mental illness. *Scandinavian Journal of Occupational Therapy*, 446-456.

Association for Savings & Investment SA. (2021, 12 01). *South Africa's life and disability insurance shortfall = R34.3 trillion*. Retrieved from ASISA: 2025

Atique-Ur-Rehman, H., & Neill , J. (2019). Cognitive dysfunction in major depression: From assessment to novel therapies. *Pharmacology & Therapeutics, 202*, 53-71.

Azharuddin, S., Katherine, V.-D., Victoria, M., Marshall, T., Calvin, B., DuMont, T., & Barker, B. (2023). Mental Health in Women. *Crit Care Nurs Q*, 46(4):336-353.

Bezerra, C. A. (2016.). Psychological distress and work stress in correctional officers: a literature review. *Ciencia & saude coletiva, 21*, 2135-2146.

Bhardwaj, P. (2019). Types of Sampling in Research. *Journal of the Practice of Cardiovascular Sciences, 5*(3), 157-163.

Bjelland , I., Dahl , A. A., Haug , T. T., & Neckelmann, D. (2002). The validity of the Hospital Anxiety and Depression Scale: An updated literature review. *Journal of Psychosomatic Research*, 66-77.

Blank, A. A., Harries, P., & Reynolds, F. (2015). Without Occupation You Don't Exist': Occupational Engagement and Mental Illness. *Journal of Occupational Science, 22*(2), 197-209.

Boland, R., & Verduin, M. (2024). *Kaplan & Sadock's Comprehensive Textbook of Clinical Psychiatry* (11th ed.). Lippincott Williams & Wilkins (LWW).

Brink, A. (2018). *Fundamentals of Research Methodology for Healthcare Professionals 4e* (4 ed.). Juta Law.

Bubanya , M., Cobb-Clark , D., & Wooden , M. (2017). Mental health and productivity at work: Does what you do matter? *Labour Economics, 46*, 150-165.

Bufano, P., Tecco, C., Fattori, A., Barnini, T., Comotti, A., Ciocan , C., & Bonzini, M. (2024). The effects of work on cognitive functions: a systematic review. *Front Psycholgy, 9*(15).

Carpenter, B., Nyirenda, M., & Hanass-Hancock, J. (2022). Disability, a priority area for health research in South Africa: an analysis of the burden of disease study 2017. *Disability And Rehabilitation, 44*(25), 7839–7847.

Chapparo, C., & Ranka, J. (1997). Occupational Performance Model (Australia): Definition of terms. *Monograph 1*, 58-60.

Chapparo, C., & Ranka, J. (1997).*Occupational Performance Model (Australia): A description of constructs and structure.* In C. Chapparo & J. Ranka (Eds.), *Occupational Performance Model (Australia): Monograph 1* (pp. 1–23). Occupational Performance Network: Sydney.

Chaudhury , P., Deka , K., & Chetia , D. (2006). Disability associated with mental disorders. *Indian J Psychiatry, 48*(2), 95-101.

Cheng, P., Tallent , G., Bender , T., Tran , K., & Drake, C. (2017). Shift Work and Cognitive Flexibility: Decomposing Task Performance. *J Biol Rhythms*, 32(2):143-153.

Cognitive impairment in substance use disorders. (2019). *CNS Spectr, 24*(1), 102-113.

Costa-López, B., Robledillo, N. R., Ferrer-Cascales, R. & Natalia, A., 2021. Relationship between Sensory Processing Sensitivity and Mental Health. *Medical Sciences Forum,* pp. DOI:10.3390/ECERPH-3-09064.

Cristofori , I., Cohen-Zimerman, S., & Grafman, J. (2019). Handbook of Clinical Neurology. *Handbook of Clinical Neurology*, 197-219.

Crouch, R., & Alers, V. (2014). *Occupational Therapy in Psychiatry and Mental Health.* Wiley Blackwell.

De Jesus, K., & O'Neil, S. (2024). A supervisor's perspective on mental illness in the. *SA Journal of Human Resource Management South African workspace*.

De Rosse, P., Barber, A. D., Fales, C. L., & Malhotra, A. K. (2019). Deconstructing Avolition: Initiation vs Persistence of Reward-Directed Effort. *Psychiatry Res*, 273: 647–652. de Souza Duarte, N., de Almeida Corrêa, L., Assunção, L., de Menezes, A., de Castro, O., & Teixeira, L. (2017). Relation between Depression and Hormonal Dysregulation. *Journal of Depression*.

Deligkaris, P., Panagopoulou, E., Montgomery, A., & Masoura, E. (2014). Job burnout and cognitive functioning: A systematic review. *Work & Stress, 28*(2), 107-123.

Demetriou, C., Özer, B., & Essau, C. (2015). Self-Report Questionnaires. *The Encyclopedia of Clinical Psychology*.

Department: Public Services and Administration, Republic of South Africa. (n.d.). *Sick leave, incapacity leave and ill health retirement in the public service.* Retrieved February 2025, 02, from https://www.kznworks.gov.za/Portals/0/Docs/PILIR%20BROCHURE%20ENGLISH.pdf

Department: Statistics South Africa Republic of South Africa. (2023). *Equality in the job market still eludes women in SA*. Retrieved February 18, 2025, from https://www.statssa.gov.za/?p=16533#:~:text=The%20labour%20force%20participation%20rate%20for%20women%20stood,force%20either%20as%20employed%20or%20looking%20for%20work.

Dhakal, A., & Bobrin, B. D. (2023). *Cognitive Deficits.* StatsPearls Publishing.

Drake, R., & Wallach, M. (2020). Employment is a critical mental health intervention. *Epidemiol Psychiatr Sci, 5*(29).

Dunstan, D., Scott, N., & Todd, A. (2017). Screening for anxiety and depression: reassessing the utility of the Zung scales. *BMC Psychiatry, 17*(329).

Ely, S., Zundel, C., Gowatch, L., Evanski, J., Bhogal, A., Carpenter, C., & Marusak, H. (2023). Attention, attention! Post-traumatic stress disorder is associated with altered attentionrelated brain function. *Frontiers in Behavioural Neuroscience*.

Falk, A., Joseph, R., Smith, S., & Wilk, A. (2023). Mood and Anxiety Disorders: Major Depressive Disorder. *FP Essent, 527*, 7-12.

Fernandes, M. A., Santos, J., de Moraes, L., Lima, J., Feitosa, C., & Sousa, C. (2018). Mental and behavioral disorders in workers: a study on work leave. *Rev Esc Enferm USP · 2018;52:e0339, 52*, 1-8.

Fernandes, T., & Santos , N. (2018). Spatial vision loss in bipolar disorder: Case series and literature review. *Psychology & Neuroscience,, 11*(4), Psychology & Neuroscience,.

Fishbach, A., & Woolley, K. (2022). The Structure of Intrinsic Motivation. *Annual Review of Organizational Psychology and Organizational Behavior, 9(1)*.

Gallagher, P., & McGinn Gray, J. (2014). Fractionation of visuo-spatial memory processes in bipolar depression: a cognitive scaffolding account. *Psychological Medicine.*

Gan, G. (2014). Health conditions that result in disability in adults. *SFP, 40*(5), 10-15.

Hansson, S., Carlstedt, A., & Morville, A.L. (2022). Occupational identity in occupational therapy: A concept analysis. *Scandinavian Journal of Occupational Therapy, 29*(3), 198-209.

Government of South Africa. (1995). *Labour Relations Act 66*. Retrieved 02 08, 2023, from https://www.bing.com/search?q=labour+relations+act+66+of+1995&form=ANNTH1&refig=a2af394f87754af4839cd8a8dffe7533&sp=2&qs=EP&pq=labour+rela&sk=EP1&sc=10-11&cvid=a2af394f87754af4839cd8a8dffe7533

Government of South Africa. (2021 August). *Policy and procedure on incapacity leave and illhealth retirement.* Pretoria: South African Government.

Government of South Africa. (2023). *Provinces*. Retrieved November 18, 2024, from https://www.gov.za/provinces

Goycolea, R., Juan C., & Dörr, A. (2021). Visuospatial Processing Decline Due to Cannabis Consumption in Nondependent High School Students. *Educational Psychology Review.*

Gunnarsson, A., Hedberg, A.-K., Håkansson, C., Hedin , K., & Wagman, P. (2021). Occupational performance problems in people with depression and anxiety. *Scandinavian Journal of Occupational Therapy, 30*(2), 148-158.

Hammar, Å., Ronold, E. H., & Rekkedal, G. Å. (2022). Cognitive Impairment and Neurocognitive Profiles in Major Depression—A Clinical Perspective. *Frontiers in Psychiatry*, 1-21.

Harrold, A., Keating, K., Larkin, F., & Setti, A. (2024). The association between sensory processing and stress in the adult population: A systematic review. *Applied Psychology: Health and Well-Being*, 2536-2566.

Harvey, P. (2019). Domains of cognition and their assessment. *Dialogues Clin Neurosci, 21*(3), 227-237.

Hendriks, S. P. (2023.). Global incidence of young-onset dementia: a systematic review and meta-analysis. *Young-Onset Dementia Epidemiology Study Group, 19*(3), 831-843.

Herman, A., Stein, D. J., Seedat, S., Heeringa, S. G., Moomal, H., & Williams, D. R. (2009). The South African Stress and Health (SASH) study: 12-month and lifetime prevalence of common mental disorders. *S Afr Med J, 99*, 339-344.

Hirsch , P., Nolden , S., Declerck, M., & Koch, I. (2018). Common Cognitive Control Processes Underlying Performance in Task-Switching and Dual-Task Contexts. *Adv Cogn Psychol*, 14(3):62–74.

Ike, K., de Boer, S., Buwalda, B., & Kas, M. (2020). Social withdrawal: An initially adaptive behavior that becomes maladaptive when expressed excessively. *Neuroscience & Biobehavioral Reviews, 116*, 251-267.

in‘t Hout, L., van Hees, S., Vossen, E., Oomens, S., van de Mheen, D., & Blonk , R. (2024). Factors Related to the Recurrence of Sickness Absence Due to Common Mental Health Disorders: A Systematic Review. *Journal of Occupational Rehabilitation*

Irwin, J. (2022). *The relationship between traumatic stress, mental well-being and work engagement in the South African Police Service (Doctoral dissertation, University of Johannesburg).*

Jackson, J. P. (2014). Depression, post-traumatic stress disorder, and functional disability in survivors of critical illness in the Brain-ICU study: a longitudinal cohort study. *Lancet Respir Med, 2*(5), 369-379.

Jayawardene, W., Kumbalatara, C., Jones , A., & McDaniel, J. (2024). Work Stress and Psychoactive Substance Use among Correctional Officers in the USA. *Psychoactives, 3*(1), 65-77.

Jellestad, L., Vital, N. A., Malamud, J., Taeymans, J., & Mueller-Pfeiffer, C. (2021). Functional Impairment in Posttraumatic Stress Disorder: A Systematic Review and Meta-Analysis. *Journal of Psychiatric Research*, 14-22.

Kapur, R. (2021). *Understanding the Types of Stress.* Delhi: University of Delhi.

Kendrick, K. (2020). Disorder- and emotional context-specific neurofunctional alterations during inhibitory control in generalized anxiety disorder and major depressive disorder.

Kessler, R., Aguilar-Gaxiola, S., Alonso, J., Chatterji, S., Lee, S., & Üstün, T. (2009, 1 January). The WHO World Mental Health (WMH) Surveys. *Psychiatrie (Stuttg)*, 6(1): 5–9.

Khalid, W. (2021). The Relationship Between Unemployment and Economic Growth in South Africa: VAR Analysis. *Forman Journal of Economic Studies, 17*(01), 1-32.

Khan, M. (2020). A Theoretical Study On Factors Influencing Employees Performance, Rewards And Motivation Within Organisation. *SocioEconomic Challenges, 4 (3)*, 114124.

Kielhofner, G. (2008). *Model of Human Occupation: Theory and Application* (4th ed.). Philadelphia: Lippincott Williams & Wilkins.

Knapp, M., & Wong, G. (2020). Economics and mental health: the current scenario. *World psychiatry: Official journal of the World Psychiatric Association (WPA), 19*(1), 3-14.

Knight, M. a. (2018). Cognitive dysfunction in major depressive disorder. *Current opinion in psychiatry, 31*(1), 26-31.

Knight, M., Air, T., & Baune, B. (2018). The role of cognitive impairment in psychosocial functioning in remitted depression. *Journal of Affective Disorders, 235*, 123-134.

Knopman , D., & Petersen, R. (2014 Oct). Mild Cognitive Impairment and Mild Dementia: A Clinical Perspective. *Mayo Clin Proc, 89*(10), 1452–1459.

Koutsimani, P., Montgomery, A., Masoura, E., & Panagopoulou, E. (2021). Burnout and Cognitive Performance. *J Environ Res Public Health., 18*(4).

Kushwaha, A., Basera, D., Kumari, S., Sutar, F., Singh, V., Das, S., & Agrawal, A. (2024). Assessment of memory deficits in psychiatric disorders: A systematic literature review. *J Neurosci Rural Pract*, 15(2):182–193.

Lindsay, G. (2020). Attention in Psychology, Neuroscience, and Machine Learning. *Frontiers in Computational Neuroscience*, 1-21.

Lukasik, K., Waris, O., Soveri, A., & Lehtonen, M. (2019). The Relationship of Anxiety and Stress With Working Memory Performance in a Large Non-depressed Sample. *Frontiers in Psychology, 10*(4).

Lui, Q., He, H., Yang, J., Feng, X., Zhao, F., & Lyu, J. (2020). Changes in the global burden of depression from 1990 to 2017: Findings from the Global Burden of Disease study. *Journal of Psychiatric Research*, 134–140.

Maloney, E. (2022). The Influence of Occupational Identity on Emotional Experience. *SageJournals, 67*(1), 100-124.

Mardon, A., Barara, G., Chana, I., Di Martino, A., Falade, I., Harun, R., & Varghese, N. (2021). *What is Work and its Impact?* Edmonton: Golden Meteorite Press.

Marques, S., Correia-de-Sa, T., Guardiano, M., Sampaio-Maia, B., & Ferreira-Gomes, J. (2024). Emotion dysregulation and depressive symptoms mediate the association between inhibitory control difficulties and aggressive behaviour in children with ADHD. *Frontiers in Psychiatry*.

Matyana, M., & Thusi, X. (2023). Unemployment and poverty in South Africa: Assessing the National Development Plan 2030 predictions. *International Journal of Development and Sustainability*, 12(6), 212-226.

Mendes, J. (2024). Understanding Attention Deficits: Causes, Impact and Management. *Clin Neuropsycho, 7:6*.

Meyer , J. C., Matlala, M., & Chigome , A. (2019). Mental health care - a public health priority in South Africa. *South African Family Practice, 61(5):25-2.*

Mokoka, M., Rataemane, S., & dos Santos,, M. (2017). Disability claims on psychiatric grounds in the South African context: A review. *SAJP, 18*(2), 34- 41.

Monteiro, E., & Joseph, J. (2023). A Review on the Impact of Workplace Culture on Employee Mental Health and Well-Being. *International Journal of Case Studies in Business, IT, and Education*, 7(2), 291-317.

Nelson, B., & Shankman, S. (2015). Visuospatial and Mathematical Dysfunction in Major Depressive Disorder and/or Panic Disorder: A Study of Parietal Functioning. *Cogn Emot., 30*(3), 417-429.

Old Mutual (2023). *Old Mutual*. Retrieved from https://www.oldmutual.co.za/v3/assets/blt0554f48052bb4620/blt32ec04838b9f8c41/5f1164af175852408c5a1f2b/KPF_Functional_Impairment_Income_Cover_RSA.pdf#:~:text=Pays%20a%20monthly%20payment%20if%20because%20of%20an,to%20three%20monthly%20payments%20for%20cer.

Oliver , K., & Njoki, T. (2019). *The Effects of Drug and Substance Abuse on Employees' Job Performance on.* United States International University – Africa. Dissertation.

Mwenge, M., Figge, C., Metz, K., Kane, J., Kohrt, B., Pedersen, G., & Murray, L. (2022). Improving inter-rater reliability of the enhancing assessment of common herapeutic factors (ENACT) measure through training of raters. *Journal of Public Health in Africa, 15*.

National Economic Development and Labour Council. (2024). *Economic and Employment Trends in South Africa.* Johannesburg https://www.nedlac.org.za/wpcontent/uploads/2024/03/Economic-and-Employment-Trends-in-South-Africa_March2024.pdf: National Economic Development and Labour Council.

Noteboom, Y., van Nassau, F., Bosma, A., van der Hijden, E., Huysmans, M., & Anema, J. (2024). A roadmap for sustainable implementation of vocational rehabilitation for people with mental disorders and its outcomes: a qualitative evaluation. *International Journal of Mental Health Systems, 18*(7).

Occupational identity in occupational therapy: A concept analysis. (2022). *Scand J Occup Ther, 29*(3), 198-209.

Oviogun, P., & Veerdee, P. (2020). Definition of Language and Linguistics: Basic Competence. *Macrolinguistics and Microlinguistics*, 1–12.

Park, Y. S., Konge, L. & Artino, A. R., 2019. The Positivism Paradigm of Research. *Academic Medicine ,* pp. 95(5):1, DOI:10.1097/ACM.0000000000003093.

Patridge, E. F., & Bardyn, T. P. (2018). Research Electronic Data Capture (REDCap). *Journal of the Medical Library Association, 106*, 142-144.

Pearson Assessments. (2025). *Repeatable Battery for the Assessment of Neuropsychological Status Update (Christopher Randolph)*. Retrieved February 2025, 03, from https://www.pearsonassessments.com/store/usassessments/en/Store/Professional-Assessments/Cognition-%26-Neuro/Repeatable-Battery-for-the-Assessment-ofNeuropsychological-Status-Update/p/100000726.html

Petersen , R. (2016). Mild cognitive impairment. *Continuum: Lifelong Learning in Neurology, 22*(2), 404-418.

Petty, D. (2024). *What are the 12 official languages of South Africa?* Retrieved February 20, 2025, from https://www.ncesc.com/geographic-pedia/what-are-the-12-officiallanguages-of-south africa/#:~:text=The%20twelve%20official%20languages%20of%20South%20Africa%20are, Language%2C%20Swati%2C%20Tsonga%2C%20Tswana%2C%20Venda%2C%20Xhosa%2C%20and%20Zulu.

Pickett, M. (2024). Memory and Ageing Workforce: Implications for Workplace Productivity. *Global Journal of Aging & Geriatric Research, 3*(2).

Pike, A., Printzlau, F., von Lautz, A., Harmer, C., Stokes, M., & Noonan, M. (Frontiers in Pyschology). Attentional Control in Subclinical Anxiety and Depression: Depression Symptoms are Accociated with Deficts in target facilitation, not distractor inhibition. *2020, 11*.

Pillay, Y. (2019). State of mental health and illness in South Africa. *South African Journal of Psychology, 49*(4), 463–466.

Polatajko, H. T. (2007). In Enabling Occupation II: Advancing an Occupational Therapy Vision of Health, Well-being, & Justice through Occupation. *CAOT Publications ACE*, 22-36.

Ramano, E., & Buys, T. (2018). Occipational Therapists' views and perceptions of functional capacity evaluations of employees suffering from major depressive disorder. *South African Journal of Occupational Therapy*, 48 (1): 9-15.

Ramsamy, R. (2019). Analysing approved incapacity leave among health professionals in the Gauteng Department of Health (Doctoral dissertation).

Randolph, C., Tierney, M., Mohr, E., & Chase, T. (1998). The Repeatable Battery for the Assessment of Neuropsychological Status (RBANS): preliminary clinical validity. *J Clin Exp Neuropsychol*, (3).

Ranka, J., & Chapparo , C. (2011). *Draft illustration of the 2011 illustration of the Occupational Performance Model (Australia).* Retrieved from Retrieved (18/01/2025) from www.occupationalperformance.com/model-illustration/

Raosoft, Inc. (2004). *Sample Size Calculator*. Retrieved November 19, 2024, from http://www.raosoft.com/samplesize.html.

Rigoli, M., Silva, G., de Oliveira, F., Pergher, G., & Kristensen, C. (2016). The role of memory in posttraumatic stress disorder: implications for clinical practice. *38*(3), 119-127.

Rock, P., Roiser, J., Riedel, W., & Blackwell, A. (2014). Cognitive impairment in depression: a systematic review and meta-analysis. *Psychol Med, 44*(10), 1-12.

Rodriguez , J., Santander , N., Almroth , M., Kreshpaj , B., Gunn, V., Muntaner , C., & Bodin, T. (2022). 2022. *Eur J Public Health, 32*(3).

Rostam, F. (2020). Anxiety and stress among. (Dissertation).

Ryan, D., & Boland, P. (2021). Scoping review of occupational therapy interventions in the treatment of people with substance use disorders. *Irish Journal of Occupational Therapy, 49*(2), 104–114.

Sadock , B. J., & Sadock , V. A. (2007). *Kaplan & Sadock's Synopsos of Psychiatry* (tenth ed.). Philadelphia: Lippincott Williams & Wilkins.

Sandoghdar, A., & Bailey, C. (2023). *What is meaningful work, and why does it matter? A guide for practitioners.* London. King's Business School.

Sarsak, H. I. (2020). Applied occupational therapy for major depressive disorder: clinical case report. *MOJ Clinical & Medical Case Reports, 10*(2).

Sasikumar, N., Roja, M., & Fathima, M. (2014). Visuospatial skills and teaching learning process. *Indian Streams Research Journal*.

Scanlan, J., & Hazelton, T. (2019). Relationships between job satisfaction, burnout, professional identity and meaningfulness of work activities for occupational therapists working in mental health. *Aust Occup Ther J, 66*(5), 581-590.

Seeberg, I., Kjaerstad, H. L., & Miskowiak, K. W. (2018). Neural and Behavioural Predictors of Treatment Efficacy on Mood Symptoms and Cognition in Mood Disorders: A Systematic Review. *Frontiers in Psychiatry, 9*(337), 1-13.

Seng, J. (2018). From Fight or Flight, Freeze or Faint, to “Flow”: Identifying a Concept to Express a Positive Embodied Outcome of Trauma Recovery. *CAsCAid Group, 25*(3).

Sepehry, A. (2014). *Self-Rating Depression Scale (SDS). In: Michalos, A.C. (eds) Encyclopedia of Quality of Life and Well-Being Research.* . Retrieved February 2025, 20, from Springer, Dordrecht. https://link.springer.com/referenceworkentry/10.1007/978-94-007-0753-5_2641

Serdar, C., Cihan, M., Yücel, D., & Sedar , M. (2020). Sample size, power and effect size revisited: simplified and practical approaches in pre-clinical, clinical and laboratory studies. *Biochemia Medica, 31*(DOI:10.11613/BM.2021.010502).

Shura, R., Brearly, T., Rowland, J., Martindale, S., Miskey, H., & Duff, K. (2018). RBANS Validity Indices: a Systematic Review and Meta-Analysis. *Neuropsychol Rev, 28*(3), 269-284.

Skapinakis, P. (2023). *Hospital Anxiety and Depression Scale (HADS)* (1st ed.). Maggino: Encyclopedia of quality of life and well-being research. Springer, Charm.

Snaith, R. P. (2003). The Hospital Anxiety And Depression Scale. *Health and Quality of Life Outcomes*, 1(1):29.

South African Government. (2013). *Protection of Personal Information Act 14.* Pretoria: South African Government.

South African Society of Psychiatrists. (2020). *Mental illness disability in the workplace – the stigma is real.* Retrieved January 29, 2022, from https://www.sasop.co.za/mentaldisabilities

Stander, M., & Korb, F. (2015). Depression and the Impact on Productivity in the Workplace: Findings from a South African Survey on Depression in the Workplace. *Journal of Depression & Anxiety, 1*.

Stander, M., Margreet , B., Helen Elizabeth, M.-J., De Beer, J., & Korb, F. (2016). Depression in the South African workplace. *South African Journal of Psychiatry*, 2078-6786.

Stren , A. F. (2014). The Hospital Anxiety and Depression Scale. *Occupational Medicine, 64*(5), 393-394.

Talatalai , M., Ramanoii , E., & Chilizaii, B. (2020). Reducing psychosocial disability for persons with severe mental illness in South Africa. *South African Health Review*, 12-17.

TIBCO Statistica®. (2023). *TIBCO Statistica® 14.1.0*. Retrieved February 16, 2025, from https://docs.tibco.com/products/tibco-statistica-14-1-0.

Timp, S., van Foreest, N., & van Rhenen, W. (2024). Effect of financial incentives on the cost and duration of sickness absence. *Plos One, 19*(6).

Trifu, S., Trifu, A., Aluaş, E., Tătaru, M., & Costea, R. (2020). Brain changes in depression. *Rom J Morphol Embryol, 8*(61), 361–370.

Trivedi, J. (2006). Cognitive deficits in psychiatric disorders: Current status. *Indian J Psychiatry*, 48(1):10–20.

Uribe, J., Pinto, D., Vecino-Ortiz, A., Gómez-Restrepo , C., & Rondón, M. (2017). Presenteeism, Absenteeism, and Lost Work Productivity among Depressive Patients from Five Cities of Colombia. *Value in Health Regional Issues, 14*, 15-19.

van Niekerk, L., Casteleijn, D., Govindjee, A., Holness, W., Oberholster, J., & Grobler, C. (2020). Conceptualising disability: Health and legal perspectives related to psychosocial disability and work. *S Afr J Bioethics Law 2020;13(1):43-51, 13*(1), 43-51.

Van Wijk, C., Martin, J., & Meintjes, W. (2021). Burden of common mental disorders in South African workplace settings. *Occupational Health Southern Africa*, 164-171.

Veloen, H. (2022). *The Numbers Gang in South African Correctional Facilities: Reflections on Structures, Functions and Culture.* Retrieved February 16, 2025, from*https://open.uct.ac.za/items/36818d1b-23a2-4835-8174-5eff3b287080*

Waller, L. (2020). Fostering a Sense of Belonging in the Workplace: Enhancing Well-Being and a Positive and Coherent Sense of Self. *The Palgrave Handbook of Workplace Well-Being*, 1-27.

Wang, X., Zhou, H., & Zhu, H. (2020). Attention deficits in adults with Major depressive disorder: A systematic review and meta-analysis. *Asian Journal of Psychiatry, 53*.

Weerdesteijn, K., Schaafsma, F., Bonefaas-Groenewoud, K., Heymans, M., Van der Beek, A., & Anema , J. (2020). Predicting return to work after long-term sickness absence with subjective health complaints: a prospective cohort study. *BMC Public Health, 20*(1095).

Warren, S., Heller, W., & Miller, G. (2020). The Structure of Executive Dysfunction in Depression and Anxiety. *J Affect Disord., 279, 208–216.*

World Health Organisation. (2001). *International Classification of Functioning Disability and Health.*

World Health Organization. (8 June 2022). *Mental disorders*. Retrieved February 16, 2025, from https://www.who.int/news-room/fact-sheets/detail/mental-disorders#:~:text=1%20in%20every%208%20people,have%20access%20to%20effective%20care

World Health Organization. (2023). *World Health Organization Guidelines on mental health at work.*Retrieved January 20, 2024, https://www.who.int/publications/i/item/9789240053052: World Health Organization.

World Health Organization. (2017). *Depression and other common mental disorders: global health estimates.* Retrieved from https://iris.who.int/bitstream/handle/10665/254610/WHO-MSD-MER-2017.2-eng.pdf.

Zeng, Y., Zhang, F., Liu, H., Li, W., Ning, Y., & Zhou, Y. (2023). Psychotic symptoms and neurocognition among patients with major depressive disorder: A chained mediation model of depressive symptoms and socio-occupational functioning. *Journal of Affective Disorders, 332*, 194-200.

Zigmond , A., & Snaith , R. (1983). The hospital anxiety and depression scale. *Acta Psychiatr Scand, 67*(6), 361-70.

Zou, Z., Wang, H., Uquillas, F. D., Wang, H., Ding, J., & Chen, H. (2017). Definition of Substance and Non-substance Addiction. *Advances in Experimental Medicine and Biology, 1010*, 21-41.

APPENDIX A: APPROVAL EMAIL TO USE THE ILLUSTRATION OF THE OCCUPATIONAL PERFORMANCE MODULE (AUSTRALIA)

From: Judy Ranka <judy.ranka@sydney.edu.au>
Sent: Tuesday, January 21, 2025 04:31
To: Annemiek Meyer <meyerannemiek08@gmail.com>
Subject: RE: Requesting premission

Hello again, Annemiek,

Thank you for the additional information. Your study sounds very interesting. Congratulations on nearing completion. I have fond memories of meeting staff from the University of Witwatersrand at WFOT Congresses. We seemed to have a shared understanding of what OT is.

YES, you have permission to use the OPM(A) model illustration. If you prefer, you may use the updated version of this illustration that contains 'spiritual' dimensions of the context (attached), or the latest version about to be published. I have attached a galley copy of a new OPM(A) book chapter that may assist you in understanding more deeply what the OPM(A) is, what it represents and how to use it in practice. This is not for distribution as there are copyright restrictions. We are not entirely happy with the appearance of this one but the publisher determined what the colour scheme was. We are working on obtaining a professional looking graphic. I hope you find this information helpful.

On another topic, my husband's sister lives in Johannesburg and her daughter lives in Plettenberg. I have visited twice and am planning to return later this year or next year. I would love to speak with students at UW about the OPM(A) and/or the approach to functional cognition we created called, "The Perceive, Recall, Plan & Perform System of Task Analysis (PRPP System)", if there was sufficient interest. Perhaps you could let your supervisor know 😉.

Best wishes
Judy

Dr. Judy Ranka
OP Network
and
Honorary Academic Affiliate

APPENDIX B: EXCEL SPREADSHEET (DATA EXTRACTION TOOL)

Coding system used for non-numerical data

Gender	Diagnosis	Icd-10	Co-morbid conditions	Occupation	PIL-TIL	RTW	OT treatment
Male-1	BMD-1	F31-1	None-1	Educator-1	TIL-1	Yes-1	Yes-1
Female=2	MDD-2	F33.-2	Pain-2	Police officer 2	PIL-2	NO-2	NO-2
	PTSD-3	F43.12-3	Hypertension-3	Department of Correctional Services-3			
	GAD-4	F41.1-4	Diabetes-4	Nurse-4			
			Thyroid condition-5	Medical professionals- 5			
				General Assistant-6			
				Maintenance or physical labour			
				Clerical work -8			
				Managerial work- 9			
				High executive functioning- 10			

Background information was captured as follows:

No. record	age	gender	diagnosis	diagnosis	diagnosis	co-morbid conditions	occupation	Temporary or permanent incapacity	RTW after the last assessment	OT treatment	sessions attended

The time of each assessment was captured as follows: (time was captured in months starting with 0 at baseline).

No. record	Baseline assessment	First review assessment	Second review assessment

Zung Self-Report Anxiety and Depression Scale and Hospital Anxiety and depression scale (both captured the client's scores at the time of each assessment data)

No. record	Baseline assessment – Anxiety score	First review assessment- Anxiety score	Second review assessment- Anxiety score

No. record	Baseline assessment – Depression score	First review assessment- Depression score	Second review assessment- Depression score

Repeatable Battery for the Assessment of Neuropsychological Status (scored for each subtest was captured in the spreadsheet as reflected in the client records at the time of each assessment. All the scores were captured in the same row, but due to space restraints, they will be depicted below in three rows.

Baseline

No. record	Immediate Memory	Visio-Spatial skills	Language	Attention	Delayed memory	Overall functional Score

First review assessment

No. record	Immediate Memory	Visio-Spatial skills	Language	Attention	Delayed memory	Overall functional Score

Second review assessment

No. record	Immediate Memory	Visio-Spatial skills	Language	Attention	Delayed memory	Overall functional Score

APPENDIX C: ETHICAL CLEARANCE CERTIFICATE.

UNIVERSITY OF THE WITWATERSRAND JOHANNESBURG	HUMAN RESEARCH ETHICS COMMITTEE (MEDICAL)

Office of the Deputy Vice-Chancellor (Research and Innovation)

TO: Ms A Meyer
School of Therapeutic Sciences
Department of Occupational Therapy
Medical School
University

E-mail: meyerannemiek08@gmail.com

CC: Supervisor: Dr TR van der Merwe
Tania.vanderMerwe@wits.ac.za
and <HREC-Medical Research Office@wits.ac.za>

FROM: Mr Iain Burns
Human Research Ethics Committee (Medical)
Tel: 011 717 1252

E-mail: Iain.Burns@wits.ac.za

DATE: 24 January 2024

REF: R14/49

PROTOCOL NO: **M230639** (This is your ethics application reference number. Please quote it in all enquiries, oral or written, relating to this study.)

PROJECT TITLE: *Implications of temporary incapacity leave on specific mental functions amongst individuals diagnosed with a common mental disorder*

Please find attached the Clearance Certificate for the above project. I hope it goes well and that an article in a recognized publication comes out of it. This will reflect well on your professional standing and contribute to Government funding of the University.

MSWorks2000\Iain0007\Clearscan.wps

UNIVERSITY OF THE WITWATERSRAND JOHANNESBURG

R49 Ms A Meyer

HUMAN RESEARCH ETHICS COMMITTEE (MEDICAL)
CLEARANCE CERTIFICATE NO. M230639

NAME: (Principal and Co-Investigators) Ms A Meyer **DEGREE:** MSc (OT)

DEPARTMENT: School of Therapeutic Sciences
Department of Occupational Therapy
Medical School
University

PROJECT TITLE: *Implications of temporary incapacity leave on specific mental functions amongst individuals diagnosed with a common mental disorder*

DATE CONSIDERED: 30 June 2023

DECISION: Approved unconditionally

CONDITIONS:

NOTE: If contact information regarding student study participants is required, please contact the Registrar's office <Nicolaen.Potgieter@wits.ac.za>

SUPERVISOR: Dr TR van der Merwe

APPROVED BY:

Ms M van Rhijn, Co-Chairperson, HREC (Medical)

DATE OF APPROVAL: 24 January 2024 **EXPIRY DATE:** 23 January 2029

This Clearance Certificate is valid for 5 years from the date of approval. An extension may be applied for.

DECLARATION OF INVESTIGATORS

To be completed in duplicate and **ONE COPY** returned to the Research Office secretariat on the 3rd floor, Phillip Tobias Building, Parktown, University of the Witwatersrand, Johannesburg.

I/we fully understand the conditions under which I am/we are authorized to carry out the above-mentioned research and I/we undertake to ensure compliance with these conditions. Should any departure be contemplated from the research protocol as approved, I/we undertake to submit details to the Committee. I agree to submit a yearly progress report in the format available at https://wits.ac.za/research/researcher-support/research-ethics/ethics-committees/. This report is due annually, for the duration of the Clearance Certificate, beginning on the first anniversary of Date of Approval above. Unreported changes to the study may invalidate the clearance given by the HREC (Medical).

Signature of Principal Investigator

02 February 2024
Date

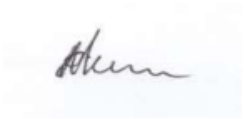
APPENDIX D: ORGANISATIONAL CONSENT FORM/APPROVAL LETTER AND INFORMATION SHEET.

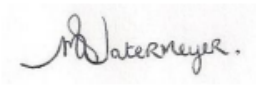
WITS UNIVERSITY

ORGANIZATIONAL CONSENT SHEET

Project Title: *Implications of temporary incapacity leave on specific mental functions among individual diagnosed with a common mental disorder.*

I Channette van der Merwe and Marlize Watermeyer hereby give Annemiek Meyer permission to access W&M Occupational Therapists company data (occupational therapy reports) for the purpose of conducting research.





Chanette van der Merwe.
Occupational Therapist
Practice owner

Marlize Watermeyer
Occupational Therapist
Practice owner

Contact details:

Annemiek Meyer, Principal Investigator, telephone no. 0798740948, or by e-mail at meyerannemiek08@gmail.com

Prof Patricia de Witt , Supervisor, e-mail at patricia.dewitt@wits.ac.za
Dr Tania van der Merwe , Supervisor, e-mail at tania.vandermerwe@wits.ac.za

Professor CB Penny, Chairperson of the Human Research Ethics Committee (Medical) at the University of Witwatersrand, on telephone no. 011 717 2301, or by e-mail at Clement.Penny@wits.ac.za.
Ms. Z Ndlovu or Mr Rhulani Mkansi, Committee Secretariat, telephone nos.: 011 717 2700 or 1234, or by e-mail at: Zanele.Ndlovu@wits.ac.za or Rhulani.Mkansi@wits.ac.za



STUDY INFORMATION DOCUMENT

Study title: *Implications of temporary incapacity leave on specific mental functions among individuals diagnosed with a common mental disorder.*

Greetings:

Introduction:

I Annemiek Meyer, am researching the implications of temporary incapacity leave on specific mental function amongst people diagnosed with a common mental disorder. Research is a process used in seeking new knowledge. In this study, I want to learn about the impact the absence of work has on specific mental functions among individuals diagnosed with a common mental disorder.

Organizational invitation: I am asking for permission to access retrospective research company data (previous occupational therapy evaluation reports).

What is involved in the study?

1. The study design is a quantitate correlation research study focused on investigating the correlation between the study variables.
2. Research data will be collected from previously compiled assessment reports. The researcher will have no direct contact with the study population within the researcher's role.
3. Identifiable information will be kept confidential.

Benefits of being in the study:

Understanding the implication of temporary incapacity leave has specific mental functions amongst mental healthcare users will greatly benefit the field of occupational therapy by increasing the knowledge base. This study aims to explore the relationship between these variables. Investigating these factors may aid in limiting disability by utilizing work as a therapeutic medium to maintain mental well-being.

Consent is voluntary: Refusal to consent will involve no penalty or loss of benefits to which the organization is otherwise entitled.

Confidentiality: Normally personal information will be treated in the strictest confidence and will only be available to the Principal Investigator (PI) and her supervisors, in the case wherein the PI is a postgraduate student. The only exceptions - and all of them are rare - would normally be:

1. Personal information may be disclosed if required by law.
2. The Human Research Ethics Committees of the University may exceptionally require personal data to respond to a formal complaint, or for a compliance audit.
3. The South African Health Products Regulatory Authority (SAHPRA) might conceivably require access to personal data if investigating a drug trial

Participants should be assured that no individual will be identified by name in any report or publication arising out of the study. Information will be deidentified to the extent where reidentification will not be possible. All data collected in the course of the study will be securely retained for two (2) years if a scientific publication arises from the study and six (6) years if there is no publication. Thereafter, it will be destroyed accordingly.

Contact details of researcher/s:

Contact number: 0798740948 Email: meyerannemiek08@gmail.com

Contact details of HREC administrator and chair – for reporting of complaints/problems. The following text is recommended:

This study has been approved by the Human Research Ethics Committee (Medical) of the University of the Witwatersrand, Johannesburg ("Committee"). A principal function of this Committee is to safeguard the rights and dignity of all human subjects who agree to participate in a research project and the integrity of the research.

If you have any concerns over the way the study is being conducted, please contact the Chairperson of this Committee, Dr Clement Penny, who may be contacted by telephone number 011 717 2301, or by e-mail at Clement.Penny@wits.ac.za. The telephone numbers for the Committee secretariat are 011 717 2700/1234, and the e-mail addresses are Zanele.Ndlovu@wits.ac.za and Rhulani.Mukansi@wits.ac.za.

Thank you for reading this Study Information Sheet.

Date: January 2023

APPENDIX E: PRACTICE CONSENT FORM.

Watermeyer and Van Der Merwe (Inc)
OCCUPATIONAL THERAPISTS

Tel. 041 582 1663 or 041 582 4003 | Accounts Tel No. 041 582 1663
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GQEBERHA (PE)
22 4th Avenue, Newton Park
& 22 Park Drive, Central

JEFFREYS BAY
AGS Deo Doxa building,
Dolly Varden Street, C-Place

KAREEDOUW
8 Riebeeck Street

PATIENT DETAILS

Full name(s) & surname: _____

ID number: _____

Postal address: _____

_____

Postal code: _____

Home address:_____

_____

I hereby give W&M Occupational Therapists permission to contact me via the following communication channels:

Cell number: _____

Email address: _____

DETAILS OF THE PERSON RESPONSIBLE FOR THE ACCOUNT (IF NOT THE PATIENT)

Full name(s) & surname: _____

Relationship to patient: _____

Cell number: _____

Email address:_____

MEDICAL AID DETAILS

Name of medical aid:_____

Plan / Option:_____

Membership no: _____

Main member surname and initials: _____

Dependent code of patient: _____

Authorisation Number: _____

TERMS AND CONDITIONS

Being a patient at this practice means that you are subject to the following, which applies every time you visit the practice:

Medical aids / medical schemes

1. If you are a member of a medical aid or a dependent on someone's medical aid, this practice will send the account directly to your medical scheme. If you do not want us to do this, please let us know immediately after you have seen the Therapist and before you leave the practice.
2. With some medical aids we do NOT submit the account, and you have to pay us, and then claim back from the medical scheme.
3. Medical aids sometimes pay less than what we charge. Sometimes they do not pay at all.

Note that you will still have to pay the full account, if you scheme do not pay in full. You may also have to pay us a portion of the account, if the scheme did not pay us the total amount.

What we charge

4. A list of our consultation fees that you have to pay if you get therapy at this practice is available at reception.
5. In some cases, we need to do something different or something more in order to help you. In such cases we will provide you with a quotation that will state what we estimate the cost would be, but also what could make the quotation go up, or down.

If you are uncertain of a quotation or fee, please talk to your therapist about the cost of your therapy.

6. The cost of materials that we use during therapy may differ and we will in each case inform you of the cost thereof, if it is not included in the consultation fee.

When you have to pay us

7. You must **pay us within 30 days** (one month) after we have given you an account. You can pay in cash at the practice or make an internet banking transfer (EFT). Our bank details are on the account. We regret we do not accept any cheques.

What could happen if you do not pay us in time

8. If you do not pay us within the 30 days, we may hand you over to a debt collecting agency or a law firm to get the outstanding monies. All costs of the debt collector and/or lawyer will be added to your account.
9. If you have any special circumstances that prevent you from in paying us, please let us know immediately, so that you can make repayment arrangements.

About therapy

10. Before we start with therapy:
10.1. We will talk to you about the options you have and the benefits of each option.
10.2 We will also tell you if there are any risks (such as risk of hurting yourself or pain) or negative aspects of the therapy.
10.3 You will then agree to the therapy after the discussions, or you may decide to refuse therapy. If you refuse, we will explain to you what might happen if you do not undergo therapy. Therapy often means more than one session and it may be important that you commit to a series of sessions.
11. Remember that:
11.1. No therapy can be 100% guaranteed.
11.2. You always have to follow the instructions and warnings of the therapist carefully.
11.3. The success of therapy depends on your co-operation and being honest with the therapist. If you feel funny or uncertain, please make a follow-up appointment with the therapist.
12. You must complete a series of therapy sessions, if this was recommended by the therapist. Stopping therapy before the end of all the sessions, may mean that the therapy will not be successful.

The Therapist has explained the therapy to me, and I fully understand the therapy I will be receiving, as well as the benefits and options available to me.

Signature: _____

Confidentiality and Protection of Personal Information

13. The team of healthcare professionals caring for you keep records about your health and any treatment and care you receive from this practice. These records help to ensure that you receive the best possible care and may be written on paper or held

on a computer. This information may include details relating to your identification and contact, billing and medical history.

14. While we make every effort to collect personal information directly from you, we may be required to obtain additional information through the collection of hospital stickers for administrative and billing purposes. Please ensure your details are correct to assist us in ensuring the highest quality of treatment and prevent unnecessary delays in your therapy.
15. We may use and disclose your information for the following reasons: Occupational therapy research (your name will be withheld), treatment, payment and health care operation. We take precautions to keep the personal information disclosed to us secure, which includes a combination of physical, technological and administrative security measures that are appropriate to the sensitivity of the information. We will not intentionally disclose such information to third parties for commercial purposes.
16. Every person that gets therapy in this practice has the right to confidentiality (this means to have your personal information kept private, even from family members and employers). Nothing that you share with the Therapist will be passed on to anyone, unless:

16.1. You agree in writing that your information can be shared (e.g. with a school teacher or an employer or anyone other specific person or entity).

16.2. The law on medical aids forces us to provide certain information to the medical aid. When we submit your account to the medical aid, the account includes personal information, such as what your health status is, and the codes (numbers) that indicate the specific therapy you received. In the case of medical aid compliance audits, we may be required to provide additional information pertaining to the treatment received.

16.3. When we receive an order from a court to disclose your information, we have no choice but to provide it.

16.4. When a specific law makes it compulsory to report things, such as TB, cancer or child abuse or child neglect.

16.5. Communication with the referring doctor or other healthcare professional, insofar as it is necessary and in the interest of the patient.

17. When anyone else, or any other business (such as an insurance company, your employer, a lawyer) want your information, we will contact you to get your written permission that we can give the information to such person or business.
18. You can withdraw your consent to have your information shared with other health care providers or other parties at any time, except where the disclosure is authorized by law. However, please discuss this with your treating therapist first.
19. You have the right to access your record in a timely manner. In extremely limited circumstances you may be denied access to your records, but only if providing access would create a significant risk to you or to another person. Patient requests for access to the medical records can be made in writing to our Information Officer in terms of our Promotion of Access to Information Act, Section 51 Manual (see office address at top of this document).
20. We retain patient records as required, and for the length of time, stipulated by law and professional guidelines. When information in no longer required, it is destroyed in a secure manner, according to set procedures.

APPENDIX F: PLAGIARISM DECLARATION

Faculty of Health Sciences, Postgraduate Office
Phillip V Tobias Building, 2nd Floor
Cnr York & Princess of Wales Terrace, Parktown 2193
Tel: (011) 717 2745 | Fax: (011) 717 2119
Email: Mathoto.senamela@wits.ac.za

UNIVERSITY OF THE WITWATERSRAND, JOHANNESBURG

PLAGIARISM DECLARATION TO BE SIGNED BY ALL HIGHER DEGREE STUDENTS

SENATE PLAGIARISM POLICY

I, Annemiek Meyer (Student number: 859837), am a student registered for the degree of Master of Science in Occupational Therapy in the academic year.

I hereby declare the following:

I am aware that plagiarism (the use of someone else's work without their permission and/or without acknowledging the original source) is wrong.

I confirm that the work submitted for assessment for the above degree is my own unaided work except where I have explicitly indicated otherwise.

I have followed the required conventions in referencing the thoughts and ideas of others.

I understand that the University of the Witwatersrand may take disciplinary action against me if there is a belief that this is not my own unaided work or that I have failed to acknowledge the source of the ideas or words in my writing.

I have included as an appendix a report from "Turnitin" (or other approved plagiarism detection) software indicating the level of plagiarism in my research document.

Signature: _____ Date: 18/01/2025

APPENDIX G: TURNITIN REPORT

IMPLICATIONS OF TEMPORARY INCAPACITY LEAVE ON SPECIFIC MENTAL FUNCTIONS AMONG INDIVIDUALS DIAGNOSED WITH A COMMON MENTAL DISORDER

by Annamiek Meyer

Submission date: 27-Feb-2025 01:08PM (UTC+0200)

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IMPLICATIONS OF TEMPORARY INCAPACITY LEAVE ON SPECIFIC MENTAL FUNCTIONS AMONG INDIVIDUALS DIAGNOSED WITH A COMMON MENTAL DISORDER

ORIGINALITY REPORT

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