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PERCEPTIONS AND EXPERIENCES

OF

RETURN TO WORK BY CLIENTS

WITH

MAJOR DEPRESSIVE DISORDER

Lebohang Etheldreda Saohatse

Dissertation submitted to the Faculty of Health Science,

University of the Witwatersrand, Johannesburg,

in fulfilment of the requirements for the degree

of Master of Science in Occupational Therapy

Johannesburg, 2017

DECLARATION

I, Lebohang Etheldreda Saohatse 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.

Signed  08 day of NOVEMBER 2017

Lebohang Etheldreda Saohatse

DEDICATION

To my parents Ben Saohatse and Fedile Saohatse.

This is for you.

ABSTRACT

Introduction: The study aimed to explore the lived perceptions and experiences of clients with Major Depressive Disorder (MDD) on early and delayed return to work (RTW); and factors perceived to affect this. The results obtained were related to an existing and identified RTW conceptual framework which was modified for clients with MDD.

Methodology: The study was conducted at a private hospital in Soweto, South Africa. A qualitative descriptive methodology was used in the study. Purposeful sampling was used to select the participants for the study. Self-report questionnaires and in-depth face-to-face interviews were used to collect data and qualitative content analysis was used to analyse the data from eight participants.

Results: Two themes emerged namely 'Waiting to RTW' and the 'Perceptions and Experience of RTW'. There were factors such as social pressures and fears about RTW that had an impact on early RTW. The results were used to modify an existing RTW conceptual framework to guide intervention for clients with MDD.

Conclusion: Clients with MDD have the ability to RTW after a period of hospitalization. There are many factors that affect early RTW and occupational therapist can play a role in improving their RTW intervention programmes to address these factors.

Key words: Return to work, Major Depressive Disorder, Perceptions and Experiences.

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NOMENCLATURE

Experiences: “The process or fact of personally observing, encountering or undergoing something” (Brandford, 2002).

Perception: The insight, intuition and or knowledge gained by perceiving or interpreting events/ experiences as well as the capacity to have such insight. Perceptions of clients with Major Depressive Disorder refer to their capacity to have insight and knowledge of their illness (Brandford, 2002).

Explore: “To look into closely” (Brandford, 2002).

Clients: Persons that are referred for assessment and who participate in occupational therapy intervention (Brandford, 2002).

Major Depressive Disorder: A common, recurrent, severe and often chronic illness (McIntyre *et al*. 2015). Major depressive disorder is an illness that causes mood disturbances and impairs client factors and performance skills resulting in dysfunctional occupational performance patterns (Duncan, 2005).

Diagnosis: The process of determining by examination the nature and circumstances of a diseased condition (Brandford, 2002).

Work: An activity that is performed through exerting efforts to produce an end product (Brandford, 2002).

Functional outcome: Planned result of occupational therapy intervention with the client’s enabled performance in their daily activities as well as participation in their job tasks without difficulties (Millward, 2005).

Return to work: Return to paid work within a defined time, which in this study was assumed to be four weeks after the diagnosis (Fadyl & McPherson, 2008).

Presenteeism: Refers to the employee returning to work but due to their medical condition, being unable to work effectively and efficiently and subsequently are unproductive (McIntyre, Soczynska, Woldeyohannes, Alsuwaidan, Cha, Carvlho, Jerrell, Dale, Gallaugher, Muzina, Kennedy, 2015).

Occupational therapy: Professional techniques that enables the clients involved to improve or enhance their participation in roles, habits and routines within different environments such as home, school, work and the community (American Occupational Therapy Association, 2014).

Early return to work: Return to work after an illness or injury within two months of the start of sick leave (Fit for Work Team, 2016).

Delayed return to work: Return to work after two months from the start of sick leave (Fit for Work Team, 2016).

Vocational rehabilitation: An intervention process whereby support is given to the client and or the employer in order to overcome the barriers faced when accessing, retaining or returning to work following an injury, impairment of illness (Ross, 2007).

Intervention Implementation: An action taken to directly influence and support the client to improve independent participation of their occupational performance areas (American Occupational Therapy Association, 2014).

Conceptual framework: A theoretical structure which comprises of ideas or concepts that are connected or related (Brandford, 2002).

Minimal verbal responses: Such as “mm-mm”, “yes” (De Vos, Strydom, Fouche, Delport, 2011).

Paraphrasing: Enables the participants to understand the questions even further

(De Vos *et al*., 2011).

Clarification: Ensures that the meaning of experiences is fully explored (De Vos *et al*., 2011).

Reflection: A process whereby statements of the participants' perceptions and experiences are reflected back to a client to ensure understanding (De Vos *et al*., 2011).

Encouragement: Facilitates the expansion of their perceptions and experiences (De Vos *et al*., 2011).

Probing: Increases the richness of the data especially around their emotional experiences (De Vos *et al*., 2011).

Injudicious: Poor judgement (Brandford, 2002).

ABBREVIATIONS

ICF	:	International Classification of Function
MDD	:	Major Depressive Disorder
RTW	:	Return to work
THP	:	Traditional Health Practitioner
WHO	:	World Health Organization
GDP	:	Gross Domestic Product
CDP: D	:	Code of Good Practice: Dismissal

CHAPTER ONE – INTRODUCTION

1.1 Background to the study

Over time the meaning of work has evolved, however the worker role has always been important in determining an individual's socio-economic status (Blank, Harries & Reynolds, 2015). Furthermore, engagement in work related activities plays a vital role in the development of an occupational identity (Blank, *et al*., 2015) and provides a social environment where workers can interact with others in a meaningful manner, feel valued; learn about self and develop self-identity as well as a positive self-esteem (Duncan, 2005), (Simpson, Byern, Gabbay & Rannard, 2015). Thus, the assumption of work by people suffering from mental illnesses has been associated with recovery, despite the persistent presence of symptoms (Schene, Koeter, Kikkert, Swinkels & McCrone, 2007). Major depressive disorder (MDD) is one such mental illness.

Clients with MDD have a high prevalence of disability and frequently report difficulties with employment (Waghorn & Lloyd, 2005), (Judd, Schettler, Solomon, Maser, Coryell, Endicott & Akiskal, 2008), (Birnbaum, Kessler, Kelley, Ben-Hamadi, Joish, Greenberg, 2009). Symptoms of MDD typically appear in the early part of the working life cycle of an individual (between 18 and 29 years) and may impact on the work career of that individual in the longer term (Patten, Wang, Williams, Currie, Beck, Maxwell & El-Guebaly, 2006), (American Psychiatric Association, 2013). Although medication is reported to assist in reducing negative symptoms such as psychosis, research suggests that medication is less effective in reducing positive symptoms experienced by clients diagnosed with MDD such as a flat affect, social withdrawal and reduced attention span (Lloyd, 2010). Such symptoms of MDD affect the occupational performance of the individual (Lam, Michalak, Bond, Tam, Axler & Yatham, 2012) particularly performance patterns such as routines and roles in the workplace (McIntyre, Xiao, Syeda, Vinberg, Carvalho, Mansur, Maruschak & Cha, 2015). Thus while working has been reported to assist in the recovery from an

episode of MDD, conversely the illness may also be further precipitated by employment stressors particularly in jobs with high work strain and poor social support (Bonde, 2008) (Aleksic, Trikulja, Cikota-Aleksic & Aleksic, 2013), as well as financial difficulties which are stressors typically associated with the working years (Van Beurden, Brouwers, Joosen, Terluin, van der Klink, van Weeghel, 2013).

The most common consequences of MDD include cognitive impairment (McIntyre et al., 2015), work and social disabilities/dysfunction (Goldberg & Steury, 2001) as well as lost productivity (Druss, Rosenheck & Sledge, 2000) due to absenteeism and presenteeism (Rantanen & Tuominen, 2011). Burton and Conti (2008) have reported that MDD is the leading illness causing absenteeism in the workplace due to its recurrent nature.

Interestingly, van der Feltz-Cornelis, Nuyen, Stoop, Chan, Jacobson, Katon, Snoek & Sartorius (2010) recommends that employers offer clients with MDD sick leave so that they can stay away from the workplace for a limited period of time and attend their appointments with the different health professionals, during admission or as an outpatient treatment period. However, prolonged absence from work may pose a serious concern with the possibility that absenteeism may lead to temporary or permanent incapacity, affecting both the employer and the employee.

Therefore, it is important that people with temporary incapacity as a result of MDD RTW as soon as possible in order to resume their normal routine and their worker role (Simpson, Byern, Gabbay & Rannard, 2015) contributing to the re-establishing of their sense of personal causation and self-esteem. However, Egbe, Brooke-Sumner, Selohilwe, Thornicroft & Petersen (2014) reports that stigma regarding mental illness, from both external sources (family, colleagues and the community) and internal sources (how the client feels about their diagnosis of MDD) may influence early RTW. Lloyd has suggested that stigma can be addressed most effectively by ensuring that

clients with mental illnesses retain their jobs and RTW as soon as possible and thus show their work potential, (Lloyd, 2010).

Importantly, prior to RTW, clients with MMD frequently need a period of rehabilitation. The main goal of rehabilitation of clients diagnosed with MDD is to regain optimal performance in their activities of daily life (ADL) and achieve independence in the social and work environments as soon as possible (Liberman, Hilty, Drake & Tsang, 2001). Occupational therapists play a key role in this rehabilitation of clients with MDD through clients participating in programmes of purposeful therapeutic activities aimed at overcoming their occupational dysfunction (American Occupational Therapy Association, 2014). To achieve this, the occupational therapist plans and executes a client-centred intervention plan that aims to attain optimal occupational performance of the client. As RTW is always a key outcome of interventions with clients with MDD, it is important that occupational therapists keep up to date with current evidence supporting best practice as well as the developing models of vocational rehabilitation to assist their clients in returning to work (Ross, 2007).

Generally clients with MDD have the capabilities to return to paid work provided that they receive appropriate intervention (Sainsbury Centre for Mental Health, 2009). Occupational therapists play a key role in ensuring that clients with MDD experience a timely and effective RTW (Ross, 2007). Schene *et al*. (2007) and Hees, de Vries, Koeter & Schene (2013) reported that occupational therapists play an essential role in ensuring clients can cope better with work demands and work related stress. However, to do this effectively it is essential that occupational therapists, providing care for clients with MDD, understand the challenges that clients face on RTW. While occupational therapists understand the nature of MDD and how it affects the work skills and productivity, this knowledge is used to develop intervention programs. However, little research has been done that focuses on evaluating the clients' personal perceptions and experiences which is thought to influence successful RTW (De Vries, Koeter, Nabitz, Hees & Schene, 2012).

Literature suggests that these clients experience considerable challenges which may not be that overt, as only about 70%-75% are reported to have returned to work within one year (Roelen, Norder, Koopmans, van Rhenen & van der Klink, 2012). This suggests that occupational therapists need to examine the clients' perspective around their RTW and gain knowledge on their experiences and perception in order to understand factors that may prevent or delay their RTW. Discussions with clients suffering from MDD reported anecdotal facilitators and barriers to early RTW following a period of sick leave and hospitalization. The clients who had returned to work early reported that their prime motivation was financial: clients reported having depleted their sick leave benefits resulting in them having to take unpaid leave thus affecting their finances over all. Other clients reported that they had not yet returned to work due to poor supervisor support, as well as poor interpersonal relationship with the supervisor, low remuneration, poor growth and development opportunities at work, which were perceived by the clients to be barriers to RTW.

There is a rehabilitation programme in the private occupational therapy practice where the researcher works, which aims to address the clients' occupational performance problems with the critical outcome being successful RTW. The programme consists of both therapeutic group work and individually prescribed task-orientated activities designed to meet clients' expressed and therapeutic needs. Collectively these various therapeutic activities address the clients' problems holistically considering therapeutic interventions as well as prevention and health promotion strategies. The programme runs for the period that the individual is admitted to the psychiatric unit which varies from 10 to 21 days. Discharge is decided by the admitting psychiatrist, in consultation with multi-disciplinary team members based on the clients' level of function following functional evaluations. Professional responsibilities by team members around the decision for a client to RTW are not well defined and failure to attend to this effectively may lead to job loss. This led the researcher to question which factors are influencing early and delayed RTW and whether these factors are perhaps covert and therefore are not being sufficiently

addressed in the occupational therapy programme to bridge the RTW process for clients who have been hospitalized for MDD.

Complicating the problem of not returning to work, is the increasing unemployment rate in South Africa which was reported to be at 27.7% in the first quarter of 2017, increasing by 1% in the last quarter of 2016 (Stats SA, 2017). This high unemployment rate leaves those suffering from ill health vulnerable.

On the other hand, successful employment is primarily dependent on the client's ability to function in the workplace. In the period just following an episode of illness due to MDD, optimal functioning may not be immediately possible (Wang, Beck, Berglund, McKenas, Pronk, Simon & Kessler, 2004). Clinical improvement in the symptoms of MDD does not necessarily mean acceptable job performance, (Bender & Farvoldem, 2008) hence there may be a number of clients that RTW but may not be optimally productive for a period after their return. Other clients may take longer to RTW due to negative perceptions about their capacity and capabilities to work (Corbiere, Renard, St-Armaud, Coutu, Negrini, Sauve & Lecomte, 2015). It is therefore imperative for occupational therapists to be able to identify those factors that may influence premature and delayed return to productive employment in order to facilitate an appropriate transition to work. The provisions of legislation, such as the Labour Relations Act 66 of 1995 (South African Department of Labour, 1995), can be used to negotiate appropriate accommodations to prevent difficulties between the employer and the employee.

The search for knowledge that explains the difficulty associated with RTW experienced by clients suffering from MDD is essential (Fadyl & McPherson, 2008). Karasz & Watkins (2006), testify that the outcome of research can only improve the management of MDD. Therefore the problem to be investigated in this study is

identifying and understanding the factors which influence early and delayed RTW based on the perceptions and experiences of clients diagnosed with MDD in a South African context.

1.2 Statement of the Problem

Little is known about the perceptions and experiences of clients with MDD regarding factors influencing an early or delayed RTW (Nieuwenhuijsen, Verbeel, Boer, Blonk & van Dijk, 2004), especially in a developing country, such as South Africa. To facilitate timely RTW of clients diagnosed with MDD, it is essential that occupational therapists providing rehabilitation services take cognisance of the challenges that these clients face when returning to work, as well as the role they play in effective RTW and the issues that need to be addressed in the rehabilitation process. By addressing these influencers it is hoped that long delays in RTW as well as clients returning to work too early, will be avoided or reduced. No South African study could be found in the literature reviewed that has examined the clients' perceptions and experiences and how these might influence early RTW following a period of hospitalization for MDD from an occupational performance perspective. Intervention related to RTW is guided by conceptual frameworks developed to ensure evidence based best practice. Despite this, there is no RTW conceptual framework for the occupational therapy intervention for clients following absence from work due to an episode of MDD. The only conceptual framework that was found was that of cancer clients by Chow, Ting & Su (2014). This conceptual framework was analysed later and was compared to the findings of this study to evaluate if a RTW conceptual framework can be used to guide the vocational rehabilitation process for clients specifically with MDD.

1.3 Research Question

What are the lived perceptions and experiences of clients with MDD that facilitate or delay their return to active employment following an episode of illness and if these

factors can be included in an existing or new conceptual framework to guide intervention?

1.4 Purpose of the study

The purpose of the study was to explore the lived perceptions and experience of clients in relation to their successful or un-successful early or delayed RTW following a period of hospitalization for MDD. The outcome of this research will inform a new or modified conceptual framework which will guide the vocational rehabilitation programme offered by occupational therapists at a private psychiatric clinic in Gauteng South Africa.

1.5 Aim of the study

The aim of the study was to explore the lived experience of clients with MDD around early and delayed RTW and the factors they perceived influence this. These client perceptions and experiences will be analysed, compared and evaluated against an existing conceptual framework identified in the literature which focuses on RTW for clients suffering from cancer. This conceptual framework will be adjusted to become a conceptual framework guiding intervention for clients with MDD, as well as the occupational therapy programme in the researcher's practice setting aimed at facilitating RTW.

1.6 Objectives

Three objectives were formulated to guide this study:

- To explore the lived **perceptions and the experiences** of RTW of clients with MDD who have returned to work.

- To explore the lived **perceptions and the experiences** of RTW of clients with MDD who have not returned to work.
- To adjust an existing conceptual framework for clients suffering from MDD to guide the occupational therapy vocational rehabilitation intervention program for these clients following an episode of absence from the workplace.

1.7 Justification for the study

Understanding of the determinants which act as facilitators and the challenges some clients might be facing when they RTW from their perspective is essential baseline information in any vocational rehabilitation process. The data collected from the study will be compared with an existing RTW conceptual framework as most conceptual frameworks have been developed predominantly for clients with physical illnesses and to determine if condition specific factors influence RTW.

The results will contribute to the existing knowledge of the management of clients diagnosed with MDD, particularly in the area of RTW. The study may also assist employers to be aware of the factors that influence RTW following a period of hospitalization due to MDD thus controlling and managing the relevant influencers of RTW, as well as making full use of legislation such as the Labour Relations Act 66 of 1995 (The South African Department of Labour, 1995) and company policies to facilitate this. This understanding may contribute to reducing the costs of long-term disability to an employer and the insurance companies, as vocational rehabilitation programmes can be geared to assisting clients diagnosed with MDD to RTW early with appropriate accommodations after sick leave, so they can contribute to the South African economy.

1.8 Conclusion

Work has considerable therapeutic benefits for clients with mental illness like MDD. Major depressive disorder is a recurrent and disabling illness which affects the clients' performance in the workplace. Occupational therapists play a vital role in the RTW process.

This chapter included a brief motivation for the study including the problem, justification as well as the aims and the objectives. Chapter 2 includes a review of current literature on mental illness from a global, African and South African perspective. Major depressive disorder in particular and finally RTW will then be discussed along with a conceptual framework detailing critical factors which have been found to relate to RTW in clients with other conditions.

CHAPTER TWO: LITERATURE REVIEW

2.1 Introduction

Occupational therapy is a client-centered profession and therefore understanding the lived perceptions and experience of clients with MDD around their RTW is important in the development of appropriate intervention programmes to enable successful early RTW. This chapter aims to describe the current literature available on MDD and RTW particularly that of the clients' perceptions and experiences so as to inform this research study.

This chapter will review both national and international scientific medical and professional literature between 2003 and 2017. Seminal literature earlier than this period was included, as it was found that RTW and MDD had been researched sporadically over the past 40 years, resulting in little new evidence. The literature was searched through the World Wide Web particularly using databases such as PubMed and EBSCO from the University of Witwatersrand and Google Scholar sites. The terms used to search for relevant literature were: RTW, work, major depressive disorder, perceptions, experiences, occupational therapy, conceptual framework and mental illness. Literature used included that from Africa, Europe, Australia and the United States of America.

The literature review is organized as follows: firstly, the global perspective of mental health and mental illness will be discussed, followed by mental illness from an African and South African perspective. Information regarding MDD, such as the diagnosis and symptoms, economic burden, absenteeism and presenteeism, will also be presented; Thereafter, the focus will shift to the importance of work for people with MDD, the prevalence of MDD in the workplace and factors influencing RTW. The role of the occupational therapist will be discussed. Finally an existing conceptual framework for RTW for conditions other than MDD will be discussed.

2.2 Global perspective of Mental health and Mental Illiness

The World Health Organization (WHO) describes mental health as a state of well-being: where every individual can cope with daily stressors, be productive and contribute to their communities (WHO, 2002). Conversely, a person may be considered mentally unhealthy or may be diagnosed with a specific mental illness if they are unable to achieve these. Thus mental illnesses are characterised by psychological or behavioural symptoms that affect functioning in daily activities and may cause risk of disability or death.

Mental illnesses contribute to the global burden of disease and are reported to affect 10% of the global adult population (WHO, 2001), (Amini, Negarandeh, Cheraghi & Eftekhar, 2013). Despite this, relatively few studies have been reported on this topic in developing countries, across the globe of which South Africa is one (Hugo, Boshoff, Traut, Zungu-Dirwayi & Stein, 2003), (Waqas, Zubair, Ghulam, Ullah & Tariq, 2014). This indicates a gap in the knowledge about how mental illness is viewed in developing continents especially African countries and particularly how clients perceive and experience it in relation to their state of employment.

2.3 Mental illness in Africa

Hugo *et al*. (2003) suggests that the prevalence of mental illnesses in Africa is comparable to that of developed countries. Most knowledge of mental illness has been described in terms of Western perspectives. However, there are African concepts and understandings of mental illnesses which are defined by the different communities or groups. Local concepts of mental illness reflect the specific knowledge and the experiences of the particular population in their own context. For instance, a study undertaken in four countries in Africa by Ventevogel, Jordans, Reis & de Jong (2013) suggested that communities attempt to firstly understand the causes of ‘unusual behaviour’ (being aggressive, walking around naked, socially withdrawn) in people despite Western definitions being well published. The

community would then decide whether these behaviours would be best treated using the western intervention or if intervention by traditional health practitioners (THP) would be preferable (Ventevogel *et al*., 2013). Therefore, it is common that some of the communities still do not accept the western concepts of mental illness and rather their own understanding to explain the strange behaviour that is not within the social norms of that context.

Whichever health care services the community chooses, the health system should always provide good quality services and protect the rights of vulnerable people such as people with disabilities and especially those that have mental illness (Semrau, Evans-Lacko, Alem, Ayuso-Mateos, Chisholm, Gureje, Hanlon, Jordans, Kigozi, Lempp, Lund, Petersen, Shidhaye & Thornicroft, 2015). A noticeable gap has been reported in African countries when it comes to accessibility and affordability of the health care system especially for people with mental illness (Semrau *et al*., 2015). This is mostly related to low financial resources, the high burden of disease (Semrau *et al*., 2015) and the colonial past of the continent which influenced the way in which health services were developed and funded. However, the WHO came up with a strategy of 'Health for All' by the year 2000 (WHO, 1978). Therefore, a considerable focus went into an innovative approach towards intervention in mental health care. Firstly this approach included improved knowledge of mental illness within the community and provision of services by practitioners providing both primary and tertiary health care (Hosman, Jane-Llopis & Saxena, 2005). In addition this approach included the integration of THPs within the conventional western orientated health treatment. In South Africa, the eight Batho Pele principles were adopted as both a policy and practical strategies to improve the accessibility and affordability of health care services (Department of Public Service and Administration, 1997).

Over the years, THPs' have been consulted by the communities in the African continent (Padayachee & Laher, 2014). Pellegrini & Ruggeri (2007) stated that 20%-80% of people with mental illness access THPs' (which include *inyanga*, *sangoma*

and spiritual healers) (Van Niekerk, Dladla, Gumbi, Monareng & Thwala, 2014) for their mental health care in preference to Western health care.

Traditional treatments such as aarti and vibbuthi in the Hindu religion (Padayachee & Laher, 2014) or herbal remedies (Gureje, Nortje, Makanjoula, Oladeji, Seedat & Jenkins, 2015), water that has been prayed for or ancestral spirits or bones have been used for centuries by the THPs. These treatments were reported to be used more prevalently as the communities did not have knowledge of the western health treatments and furthermore these were not accessible to all. Although there is a slow shift towards using the western health treatments, it has been reported that there are about 100 times more THPs than the western medical practitioners in sub-Saharan Africa (WHO, 2002), (Ventevogel *et al.,* 2013) thus making them much more available and easier to access. The THPs' availability has made it easier for the community to consult them more frequently than the western medical practitioners, hence the mentally ill consult western health services long after their symptoms are evident and the impact on ADL is clearly evident.

Research has suggested that clients often use both of these health systems: clients will consult the THPs for an explanation of the illness and the western medical practitioners for symptom relief (Crawford & Lipsedge, 2004). Payment for these health services also differ and most clients perceive the heath care by THP as being more affordable (Gureje *et al*., 2015). Generally, THPs take a deposit and only receive a final payment when a client is "cured". Consequently, this practice also increases the clients' hope that their illness may be cured. A study conducted in the rural communities of South Africa reported that western medical practitioners were opposed to the idea that THPs made clients believe that mental illness can be cured. This concern resulted in some of the western medical practitioners in believing that THPs promote non adherence to medication regimes and relapse. This study suggested that this was one of the reasons supporting the non-inclusion of THP in the intervention of mental illnesses (Campbell-Hall, Petersen, Bhana, Mjadu, Hosegood, Flisher & MhaPP Research Programme Consortium, 2010).

2.4 Mental health care services and Mental illness in South Africa

The past segregated nature of South Africa has made it challenging to obtain a national representation of the prevalence of mental illnesses (Stein, Seedat, Herman, Moomal, Heeringa, Kessler & Williams, 2008). However, it has been estimated that one in six South Africans will be diagnosed with a mental illness in their life time (Bateman, 2015).

The lack of specific prevalence data with respect to mental illnesses is also coupled with poor utilisation of the mental health services (Williams, Herman, Stein, Heeringa, Jackson, Moomal & Kessler, 2008). The poor use of mental health services has been attributed amongst others to the persistent and profound stigmatization of mental illness in addition to the country's history, the migrant labour system and dispossession of the majority of South Africans under apartheid (Coovadia, Jewkes, Barron, Sanders & McIntyre, 2009). In 1998, only 2.5% of the national health budget (the health budget was 8.5% of the GDP) was allocated to mental health (South African Depression and Anxiety Group, 2010). The effects of a historically poor delivery of mental health care service to the majority of South Africans is still evident, 22 years into democracy, especially in rural areas with communities struggling to access mental health care services, which are mostly located in urban areas (Harris, Goudge, Ataguba, McIntyre, Nxumalo, Jikwana & Chersich, 2011), (Ventevogel *et al*., 2013). Even the public mental health care services located in urban areas, have minimum resources available for the people to access (South African Human Rights Commission, 2009). Impoverished people in rural communities are most compromised, as they cannot afford to travel the vast distances often required to access healthcare services and are often late in seeking help. A study by Harris *et al*. (2011) confirmed that people living in rural Eastern Cape and Limpopo took longer to seek health care due to travelling distances and transport issues.

In South Africa an additional problem is the inequality in the provision of healthcare between the private and the public sector. The private health sector is well resourced

but provides services to a relatively small proportion of the population (46%) that access private health care using medical aids (Coovadia *et al*., 2009).

Unfortunately, having a medical aid does little to enable mentally ill clients (17.5% of the population) to access private mental healthcare facilities (Staff Writer, 2016). Medical aid schemes create rules to limit their liability, and thus access to prolonged mental healthcare services (which by the nature of the mental conditions usually are longer term than physical conditions) for members who are mental health care users is curtailed. This is a strategy used to control and save costs by the medical aid schemes (Rothberg, Magennis & Mynhart, 2009). Bateman has suggested that due to these difficulties, three quarters of South Africans diagnosed with mental illness are not treated (Bateman, 2015). Yet the highest percentage, ±85% of the population requiring mental health, are dependent on the public health system with limited resources of only 18 funded beds (and even fewer health care workers) for every 100000 people (WHO, 2007).

In an attempt to address the inequality of the two-tiered health system, a comprehensive and accessible primary health care system was introduced in South Africa. This was done through the National Health Policy Guidelines for Improved Mental Health in South Africa 1997 (South African Department of Health, 1997) and the National Health Care Act 63 of 2003 (South African Department of Health, 2003) embodied in the Mental Health Care Act 2002. Unfortunately, as in many countries in the world, due to poor human resources (i.e. 9.3 practitioners per 100000 people), limited financial resources (WHO, 2007) and stigmatization (Ross & Goldner, 2009), patients with mental illnesses, particularly MDD, often go unnoticed in primary health care settings (Hugo *et al*., 2003).

2.5 Major Depressive Disorder

It has recently been reported that MDD affects about 5%-10% of the world's population (Amini, Negarandeh, Cheraghi & Eftekhar, 2013). In the USA alone, the

prevalence of MDD had risen from 13.8 million adults in 2005 to 15.4 million adults in 2010 all under the age of 50 years (Greenberg, Fournier, Sisitsky, Pike & Kessler, 2015). The lifetime prevalence of MDD is estimated at 9.8% in South Africa (Tomlinson, Grimsrud, Stein, Williams & Myer, 2009); with 18.3% of the South African population receiving treatment for depression at any given time (Stander, Korb, de Necker, de Beer, Miller-Janson & Moont, 2016).

Females have a 1.75 chance of being diagnosed with depression, while men have only 1.3 chance in South Africa (Tomlinson *et al*., 2009), whilst other studies in the United States have found it difficult to estimate the difference between the genders (Carter & Garber, 2011).

The onset of MDD typically occurs between 20 and early 30's (Klein, Glenn, Kosty, Seeley, Rohde & Lewinsohn, 2013) with an average age of onset at 26 years in South Africa (Tomilson *et al.,* 2009). This is the age which usually coincides with the beginning stages of a person's working life (Patten *et al.,* 2006), resulting in the illness's impact on work performance as significant (McIntyre *et al*., 2015).

Major depressive disorder is a condition that affects participation in most areas of occupation, i.e. school, the workplace and home (Greenberg, Weissberg, O'Brien, Fredericks, Resnik & Elias, 2003). The illness is also associated with poor work functioning and disability (Kessler, Zhao, Blazer & Swartz, 1997).

Research has failed to determine a single specific cause of the illness (Fava & Kendler, 2000), it is apparent that genetics, life events and the environment to which an individual is exposed, may influence their sensitivity to the illness (Bonde, 2008). It is also reported that some individuals currently diagnosed with MDD may have had episodes of depression in childhood (Fava & Kendler, 2000) and may have other episodes in their lifetime (Bonde, 2008).

The nature of MDD is that the episodes are usually prolonged and that it may progress to being chronic with high incidences of a relapse and thus may be recurrent (Young, 2001).

2.5.1 Diagnosis of Major Depressive Disorder

A multidisciplinary team approach is desirable in the assessment, diagnosis and treatment of MDD. The diagnosis should be confirmed by a qualified and registered psychiatrist. In the researcher's work context, the Diagnostic and Statistical Manual of Mental Disorders 5th Edition (DSM 5) is used to guide the diagnosis of MDD. The DSM 5 is a classification tool that provides a holistic approach which also aims to improve the mental health knowledge of clients, medical aids, other health professionals and the community (American Psychiatric Association, 2013).

An important difference between the DSM5 and earlier versions (such as the DSM IV TR) is the omission of the axial diagnosis. However medical aid schemes in South Africa still use the axial diagnosis consistent with the DSM IV TR, and therefore, in the researcher's practice, information is sent to the medical aids schemes in this format:

- **Axis 1**: states the mental illness, such as Schizophrenia, General Anxiety Disorder, Bipolar Mood Disorder or Major Depressive Disorder, etc.;
- **Axis 2**: indicates a personality disorder or pervasive developmental disorder (such as Autism Spectrum Disorder);
- **Axis 3**: indicates medical conditions such as Hypertension, Diabetes Mellitus, amongst others;
- **Axis 4**: indicates the psychosocial stressors that may contribute to the diagnosis identified in the first axis which may be work related stressors, family conflict or financial stressors to name a few; and lastly
- **Axis 5**: suggests the rating of Global Assessment of Functioning (GAF) which is associated with the absence or presence of the symptoms related to the client's ability to function in their areas of occupation (Duncan, 2005). The GAF score is particularly relevant to the occupational therapy profession and continues to be used by the researcher in her work setting in determining the functional progress of the clients.

To make a diagnosis of MDD, the DSM-5 prescribes that the client must have five or more symptoms that have been persistent for over two weeks and deterioration from the client's typical level of functioning must be present. One of the symptoms needs to either be a depressed mood or loss of interest or pleasure. It is however important that no symptoms should be attributed by other medical conditions such as Diabetes, HIV, Osteoarthritis, etc. In order for an appropriate diagnosis an individual needs to present with the following symptoms indicated in Table 2.1 below, (DSM-5):

Table 2.1 Symptoms of Major Depressive Disorder

Physical Changes	**Cognitive Changes**	**Emotional Changes**	**Behavioural Changes**	**Work changes**
Loss of energy or fatigue Weight loss or weight gain Insomnia or hypersomnia Psychomotor agitation or retardation	Poor decision making Poor concentration Poor attention span	Depressed mood (sadness, emptiness, hopelessness) Loss of interest or pleasure Inappropriate guilt Worthlessness Thoughts of death (suicidal ideas with or without a plan)	Distress or impairment in social and occupational areas	Inability to meet job demands Decreased productivity High absenteeism

Adapted from (Duncan, 2005), (McIntyre, Cha, Socynska, Woldeyohannes, Gallaugher, Kudlow, Alsuwaidan & Bakran, 2013)

Intervention of MDD also includes the MDT and is usually initiated by pharmacological treatment by the psychiatrists (Siqueira, Valiengo, Carvalho, Santos-Silva, Missio, de Sousa, Di Natale, Gattaz Moreno & Machado-Vieira, 2016). Then followed by interventions by other professionals such as psychologists with cognitive behavioural therapy (British Psychological Society, 2010), occupational therapists focus on improving function (to be discussed later) and social workers who focus on the barriers in the social environment of the client (Tyler, 2010).

2.5.2 Economic burden of Major Depressive Disorder

Depression is reported to place both a social and an economic burden on a country (Millward, Lutte & Purvis, 2005) effects seen prominently in South Africa (Bateman, 2015). Depression has both direct and indirect costs (Hu, 2006). In South Africa the economic burden of MDD is estimated at a loss of 2.2% of the country's gross domestic product (GDP) (Bateman, 2015). Factors that contribute to the economic burden include the prevalence of the illness, the impairment of the people affected which are considered indirect costs, as well as direct costs (which can be considered as healthcare costs) (Greenberg, Kessler, Birnbaum, Leong, Lowe, Berglund & Corey-Lisle, 2003).

The indirect costs of depression appear to have the greatest effect in the workplace. These include loss of productivity, decline in work quality, errors in the work done and long absences from work (Greenberg *et al.,* 2003), (Crouch & Alers, 2005), (Millward, Lutte & Purvis, 2005), (Lagerveld, Blonk, Brenninkmeijer, Wijngaards-de Meij & Schaufeli, 2010). Amongst all illnesses, depression contributes the highest to the indirect costs of a company. Although no South African figures could be found, in 2010, in the USA, the burden of MDD was predicted to be between 48%-50% of both the workplace costs and the direct cost of the illness to the individual (Greenberg *et al*., 2015). This was based on the underlying symptoms such as behavioural issues (low motivation) as well as cognitive problems (poor concentration), which may continue for a time after a period of intervention (Greenberg *et al*., 2003).

Literature reports that the significant number of clients with MDD that are absent from the workplace contribute to the indirect costs (Wang *et al*., 2003). In the USA literature reports varying figures about days lost due to MDD. Druss, Rosenheck and Sledge (2000) estimated that 4.8 work days were lost in an average of three months due to depression. Gilmour and Patten (2007) reported a much higher figure with an average of 32 days being lost in 12 months due to MDD which is a figure that has increased over time. A similar trend has been found in South Africa where an

average 27.2 days are to be in a period of 12 months (Mall, Lund, Vilagut, Alonso, Williams & Stein, 2014) due to depression. Kolb (2015) noted a recent increase to 57 days in 12 months being lost due to depression. Absenteeism from the workplace due to MDD is prevalent (Rantanen & Tuominen, 2011) and has been recognized as a visible loss to a company (Druss, Rosenheck & Sledge, 2000), (Dionne, Bourbonnais, Fremont, Rossignol, Stock, Nouwen, Larocque & Demers, 2007), (Bender & Farvoldem, 2008). Notably, an absence of 57 days in one year as reported by Korb (2015) exceeds the legislated allocation of sick leave of 30 and 36 days in a three year cycle in terms of the Basic Conditions of Employment Act 75 of 1997 (The South African Department of Labour, 1997). This may result in employers taking measures to limit the cost of absence, e.g. requiring an employee to use annual leave and unpaid leave for the excess sick leave. This results in costs for the employee, or an insurer, should provision be made for temporary incapacity leave.

Absence from the workplace by employees with mental illnesses such as depression is reported to be much higher than other illnesses mainly due to the longer period of sick leave requested (Van Beurden *et al.,* 2013). Millward *et al.* (2005) advised that strategies are needed to decrease the consequences of symptoms of MDD to employers. Mall *et al.* (2014) proposed that early intervention is an important strategy in curbing the disabling nature of mental illnesses including depression. Another indirect cost to the economy caused by depression is presenteeism (Bender & Farvoldem, 2008), (McIntyre *et al*., 2015).

2.6 Work and it's importance to people with Mental illness

Work can be an important activity that provides quality of life and enables the individual involved therein to engage socially thus encouraging a social role and promoting social inclusion (Ross, 2007). Work promotes self-identity thereby developing self-concept and self-esteem (Blank & Hayward, 2009). There are different types of work in which people may engage namely paid work (for financial

gain) and unpaid work (to contribute time and resources to an NGO, charity or facility of choice), (Ross, 2007). There are also many benefits to work but its meaning and value may differ according to individuals (Ross, 2007). Therefore rewards of work, such as good salaries, may also be more important than the intrinsic meaning of work (Ross, 2007) such as a means to develop self-identity and self-esteem.

While many people experience their worker role as satisfying and meaningful there are others who are exposed to considerable challenges at work which may impact their ability to participate fully in the worker role they have assumed. These challenges may include: too much or too little work to do, not finding meaning in ones' duties, poor communication with the supervisor/manager/fellow workers, work politics, poor work progression, being unappreciated, etc. (Mood disorders Association of Manitoba, n. d.).

Work stressors and social stressors may contribute to a mental illness and a diagnosis of MDD which in turn affects people's dignity and confidence to resume their daily activities. Particularly for the individuals that experience social pressures such as being a sole breadwinner or trying to prove one's capabilities in the work place. Engaging in an occupation, particularly work, makes it possible for an individual with mental illness to regain/maintain their own dignity (Mikkelsgard, Granerud & Hoye, 2014). Unfortunately, the nature and extent of the worker role responsibilities may negatively influence clients with mental illness (Khalaf-Beigi *et al*., 2015). However, there are South African laws which enable participation and engagement of people with disabilities in the workplace. These include reasonable accommodation defined by the Employment Equity Act, 55 of 1998 under the Code of Good Practice (The South African Department of Labour, 1998), is prescribed practice that ensures that disability is accommodated so as to enable the client to perform their job tasks (Mancuso, 1990). The employer is therefore obligated to provide reasonable accommodation when the employee has disclosed their disability and requested it (The South African Department of Labour, 1998). However, reasonable accommodation depends on the following (Mancuso, 1990):

- The financial resources of the company,
- The number of employees in the company,
- The cost and the nature of the accommodation,
- The impact of the accommodation on the operations of the company.

Working has been perceived as part of recovery for clients with MDD (Ross, 2007), (Lloyd, 2010). Therefore, it is important that clients experience a smooth transition back to the workplace after a period of illness. When RTW is delayed or does not happen, clients may experience a sense of hopelessness, lack of purpose, poor self-esteem and loss of structure and routine (Duncan, 2005). An inability to RTW may result in unemployment and poverty, as people with mental illness are reported to be the poorest in both developing and developed countries (Tampubolon & Hanandita, 2014).

2.7 Presenteeism

The additional factor which contributes to the indirect loses of the economy has been presenteeism (Bender & Farvoldem, 2008), (McIntyre *et al*., 2015). This is reported to be a consequence of injudicous RTW. It is a process that has always existed but is difficult to measure due to lack of research (Beaton, Bombardier, Escorpizo, Zhang, Lacaille, Boonen, Osborne, Anis, Vibeke, Strand & Tugwell, 2009). Presenteeism is more common and often more costly than absenteeism (Stewart, Ricci, Chee, Hahn & Morganstein, 2003) and it is estimated to account for 1.5 more work days lost compared to absenteeism (Wynne-Jones, Buck, Vanava, Phillips & Main, 2009). This is in contrast with a research by Cocker, Nicholson, Graves, Oldenburg, Palmer, Martin, Scott, Venn and Sanderson (2014) who found that the costs of absenteeism from the workplace were still substantially higher than presenteeism amongst the entire workforce. It was also reported that presenteeism may result in future absenteeism (Bergstrom, Bodin, Hagberg, Aronsson & Josephson, 2009) and may perpetuate financial loss to the employer. This is particularly relevent in MDD as it is

well described that the symptoms of MDD causing impairment in functioning still exists when the client is considered well enough to RTW, and this residual impairment may result in reduced productivity in the workplace after a client has returned to work (Sanderson, Tilse, Nicholson, Oldenburg & Graves, 2007).

Lam *et al.* (2012) conducted a study focusing on the impact of residual symptoms on function when clients diagnosed with MDD RTW. Thus, 66% of the participants reported that they have psychomotor retardation, lowered energy, poor motivation and drowsiness during the day (arnegia), 54% of the participants reported feeling irritability and anxiety (tension) and 52% of the participants reported poor memory and concentration (cognition). The presence of these symptoms may contribute to clients'reduced ability to perform the job tasks (Adler, McLaughlin, Rogers, Chang, Lapitsky, Lemer, 2006) even after symptom reduction.

Return to work plays an important role in the recovery of the clients diagnosed with MDD (Ross, 2007) , however returning to work too soon may become a concern due to the different work demands that require both cognitive function as well as physical function. Importantly, an increase in errors or loss of productivity may result in a disciplinary hearing, with potentially severe consequences for the client involved.

2.8 Prevalence of Major Depressive Disorder in the workplace

The prevalence of MDD in the employed population has never been clearly recorded in South Africa. This is essential data needed to understand the cost of depression to the employer and should be a topic for future studies.

However, depression is known to be prevalent in the workplace in the USA (Goldberg and Steury (2001). It is estimated that 6.4% of employed individuals will be diagnosed with MDD over a period of twelve months (Kessler, Merikangas & Wang, 2008) in the workplace in the USA. By contrast, in South Africa 18.3% of employees were found to be taking medication for MDD (Welthagen & Els, 2012) which indicates a higher number compared to other countries. The increasing number of adult

employees taking medication for MDD has resulted in an average household earning loss of R54 121 per year (Bateman, 2015).

It has been reported that clients with MDD frequently wish to stay away from the workplace for a longer time than is necessary, thus increasing the risk of isolation, fears of dealing with stigma from colleagues and self-pity (Bilsker, Wiseman & Gilbert, 2006). Moreover, prolonged absence from work perpetuates conditions of poverty especially in South Africa (Bateman, 2015) where the unemployment rate is 26.6% (Statistics South Africa, 2017). These factors may therefore negatively influence the clients' RTW process. Due to the impairing and disabling nature of MDD (Korb, 2015), clients experience varying degrees of limitations in occupational performance areas and dysfunction in performance skills, including poor socialization, restricted participation in important activities, as well as decreased efficiency and effectiveness at work (Duncan, 2005). Return to work in good health is an important functional outcome for clients with MDD, but this may be (positively or negatively) affected by several factors such as the client's motivation, support from the family and colleagues, work policies, etc.

2.9 Role of the Occupational therapist in Mental health

Mental health care is a recognised field of practice within the occupational therapy profession. The role of occupational therapists is to be involved in promoting mental health with the focus of intervention shifting towards prevention of mental illness and promotion of mental health according to the Mental Health Care Act of 2002 (The South African Department of Health, 2002). There are a number of interventions that can be implemented to address decline in function following a diagnosis of mental illness. These can include (Castaneda, Olson & Cargill, 2013):

- Group programmes to address assertiveness, stress management , interpersonal and social skills,

- Modifying skills that enable independent living such as community mobility,
- Exploring leisure interests and pursuits,
- Enabling the clients to be independent in personal management,
- Consulting with employers regarding accommodations at work,
- Performing functional evaluations to ensure successful RTW.

It is important that the clients diagnosed with MDD receive adequate intervention at all times. Liberman *et al.* (2001) states that rehabilitation of clients with MDD consists of a comprehensive intervention carried out by different health professionals occurring simultaneously. It is important that a team of about four professionals are involved in providing holistic intervention for people with mental illness as more may decrease the one on one interaction between the health professional and the client (Liberman *et al*., 2007). Occupational therapy is one such profession that can positively contribute to the recovery of clients' with MDD.

In the previous section of this review RTW was highlighted as an important outcome of treatment since the effects of long term absenteeism from work is a burden to the economy specifically for the condition of MDD (Millward, Lutte & Purvis, 2005). Occupational therapists play an essential role in the RTW of people with disabilities, and in particular clients suffering from MDD (Brewin & Hazel, 2007). The inclusion of occupational therapy in the treatment of MDD improves overall functioning of the client, particularly the occupational performance areas which have been affected by MDD (Schene *et al.,* 2007).

Vocational assessment and rehabilitation, especially in mental health care settings, has a number of outcomes: helping the client to transition back into the worker role and keeping the job after a period of illness; and providing these clients with strategies, techniques and support regarding coping with work-related stressors, (Schene *et al.,* 2007). Vocational rehabilitation follows the process mentioned below (Buys & van Biljon, 1998):

a. Screening:

The therapist will

- analyse the referral ensuring that it is appropriate,
- review the collateral information,
- conduct a background interview,
- set goals and plan with the client.

b. Work assessment:

- Job analysis (looking at the requirements of the work the client does),
- Prevocational assessment (such as self-presentation, time management and all the other related skills),
- Clinical assessment (both mental and physical skills that the client has in relation to the job requirements),
- Work abilities and skills assessment (work habits, work endurance, work speed and others).

c. Vocational planning

- Establishing a RTW strategy,
- Formulating both short term and long term goals.

d. Preparation for RTW

- Different treatment programmes to enable the client to be employable thereby improving occupational performance areas such as personal management, survival skill and others.

e. Placement in an existing or new job

- Training in job seeking skills if alternative employment is considered,
- Accommodation and environmental adaptation.

f. Follow-up

- Ensuring career development.

Vocational rehabilitation will assist in assessment of the facilitators and barriers in the workplace through performing work analysis and identifying the appropriate workplace accommodation in order to facilitate successful RTW (Esselman, Askay, Carrougher, Lezotte, Honavalahalli, Magyar-Ruseli, Fauerbach & Engrav, 2007). Occupational therapists do this by addressing different psychosocial environments in order to improve the fit between the client, the job and the environment (Keough & Fisher, 2001). Psychosocial environments are addressed through using different evidence-based technologies (such as appropriate group facilitation, counselling, ergonomics) to execute intervention appropriate for the client (Tsang, 2001). In the interest of health and wellness promotion and prevention of recurring disease and disability, vocational rehabilitation also helps to identify work related factors that may compromise health and negotiate transitional employment or reasonable accommodation for the client in the short and longer term (Creek & Lougher, 2008).

Prior to providing a client-centred intervention, an analysis of personal factors and client factors is undertaken whereby the following maybe assessed according to the impairment: cognitive function such as memory; attention span; money and mathematical skills; problem solving; abstract thinking; judgment, etc. (Chappell & Higham, 2003). Based on the assessment findings occupational therapists design individual and group occupation-based programmes to facilitate essential occupational performance areas such as social skills, anger/stress management, coping strategies, role development and independent living skills which could assist the individual with coping with pressure and social aspects of work (Duncan, 2005). Flach, Leese, Heron, Evans, Feder, Sharp & Howard (2011) report that an improvement in coping skills provided in therapy also improves RTW. Without sound knowledge on all the factors that may influence RTW, the occupational therapist may find it difficult to carry out his/her assessment such that an intervention is planned and executed for the client.

2.10 Conceptual Framework for return to work

Over time a number of conceptual frameworks focussing on RTW for people with different illnesses have been developed. A conceptual framework aims to give a holistic view of the process of RTW and assist in understanding the relationships between factors influencing this process. Conceptual frameworks such as the cancer conceptual framework (Chow *et al*., 2014), functional capacity evaluation conceptual framework (Gibson & Strong, 2003), and the use of ICF as a conceptual framework (Leyshon & Shaw, 2008) are described in the literature and assist health professionals in providing specific vocational interventions for clients affected, making recommendations to employers in accommodating employees and policy makers to review the current health care delivery practices (Chow *et al.,* 2014).

Chronic illnesses such as mental illness, cancer, and back pain, affect a wide range of people of differing age groups that are employed, and not just the elderly or people that are unemployed (Chow *et al*., 2014). Many employed people who have been ill will need to RTW after recovery or be accommodated in the work place if full recovery is not possible immediately or in the longer term. Unfortunately these chronic illnesses are associated with health risks and long sick leave. Thus understanding the need of all role players is essential when developing specific conceptual frameworks for the process of RTW. Return to work can be a difficult process and a conceptual framework can be helpful in that it can assist in identifying barriers and facilitators giving direction for the client's successful RTW. A number of the existing conceptual frameworks for RTW have used the ICF to guide their development. The World Health Organization has approved and introduced the International Classification of Functioning, Disability and Health framework (ICF) in May 2001 (WHO, 2001). The ICF provides the user with an understanding of a modern definition of disability and its multi-factorial nature, (Dahl, 2002). The ICF does not only focus on the medical-model perspective that disability is caused by and causes ill-health, but uses a bio-psychosocial approach which includes environmental factors as well as personal factors, (Dahl, 2002). Importantly the ICF also describes activity

restrictions and participation limitations which include among other the clients' ability to work. However an important component that is missing is the client's point of view regarding factors that may influence RTW, which is a limitation of the ICF. Hence the ICF was not used in the current study.

Chow *et al*. (2014) developed a RTW conceptual framework for cancer survivors which not only consisted of physical barriers but psychosocial factors too. This conceptual framework considers RTW for cancer survivors under five categories namely: financial factors, health status, work demand and work ability, environmental factors and personal factors. (See Figure 2.1)

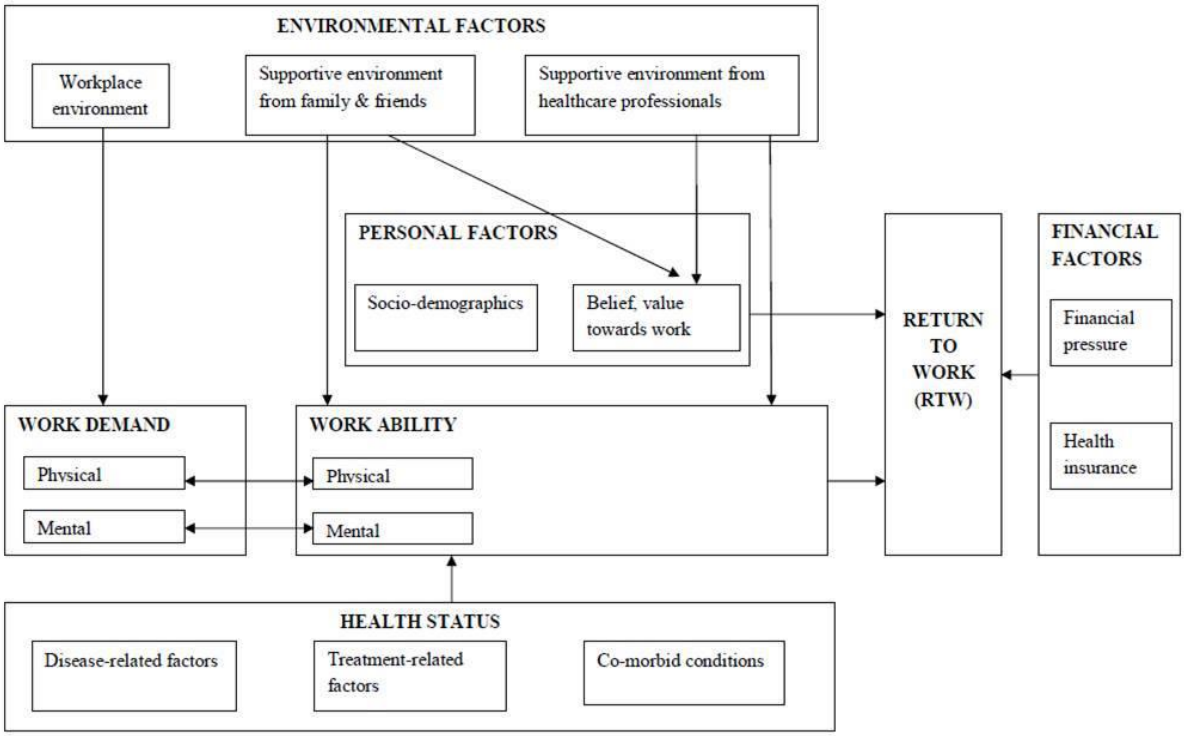

Figure 2.1: The RTW conceptual framework for cancer survivors by Chow, Ting and Su (2014) pp. 401.

This conceptual framework (see figure 2.1) identified the relationship between work abilities and work demands as a key factor in RTW of cancer survivors as they need

to match at all times in order for the client to be able to perform their work duties. When a client is diagnosed with a chronic illness like cancer, both the physical and the mental skills may have been affected by strain of the illness and pharmacological intervention. Thus when these are affected, the work demands may be too strenuous (e.g. manual labour, too many hours, increased workload) such that the work demands do not match the work ability. The way the client feels about their health condition (severity, treatment, side effects) has also been highlighted as important as it is reported that poor health status is associated with long sickness absence from the work place (Chow *et al*., 2014). The development of this conceptual framework is the first step in understanding the client's perspective regarding their health condition although their own experience on RTW is not highlighted. This conceptual framework has, however, taken a valuable step in vocational rehabilitation particularly for cancer survivors. This is predominantly so because cancer survivors now have an opportunity to RTW provided that all the factors (from the conceptual framework) influencing RTW are evaluated prior and monitored closely. Secondly this conceptual framework informs policy makers about the important role that families and health professionals can play in a successful RTW (Chow *et al.,* 2014). Lastly it is important to notice that many factors (such as the work environment, poor support from the family and residual symptoms amongst others) can affect RTW and all these somehow influence each other in that process, thus should not be looked at in isolation. The purpose of reviewing this conceptual framework was to establish if it had any value for clients with MDD. The conceptual framework identified five categories; identifying current knowledge with respect to MDD will be discussed below:

2.10.1 Return to Work

Return to work is an important but complex process by an employee that occurs following an injury or an illness as they re-establish their worker role and return back to their workplace. Keough and Fisher (2001) warn that it is not always an easy

process. Return to work is considered to be a process that carries important economic implications (Lacerte & Wright, 1992) as it can be lengthy. Van Beurden *et al*. (2013) reported that only 50% of the employees diagnosed with MDD RTW if they have been sick for six months and more. This indicates a decline from an earlier but similar study in Norway which reported that 73% of employees returned to work after 6 months (Nystuen, Hagen & Herrin, 2001). According to Brewin and Hazel (2007), RTW may be affected by the following complicated issues: the individual's personal factors (cognition, physical and emotional components), work factors and social factors (interaction) that continue to exist even after comprehensive rehabilitation.

2.10.2 Factors influencing to return to work

To date, the literature available has been focusing on presenteeism and absenteeism due to depression, (De Vries, Koeter, Nabitz, Hees, Schene, 2012), and little literature on the process of RTW and on the lived experiences of clients with MDD on RTW.

2.10.3 Personal Factors

According to Brouwers, Terluin, Tiemens & Verhaak (2009), the longer a client is absent from the workplace before seeking intervention, the longer it may take them to RTW. A number of different personal factors, e.g. gender, marital status and insight, have been identified that may or may not impede RTW and will be discussed below.

A gender difference has been reported regarding early RTW (Dionne *et al*., 2007). Vemer, Bouwmans, Zilstra-Vlasveld, van der Feltz-Cornelis & Hakkaart-van Roijen (2013) reported that women take longer to RTW than men. Bromberger, Schott, Kravitz & Joffe (2015) also supported that married women took longer to RTW than single women. This has been attributed to the traditional role that men usually occupy in the society which is that of bread winners (Dionne *et al*., 2007), (Brewin & Hazel, 2007). This may not apply in every household as some households are

headed by women as single parents and bread-winners; therefore these women may RTW earlier like Bromberger *et al*. (2015) reported.

Lack of knowledge about mental illness (due to level of education and traditional beliefs about mental illness, such as being bewitched) may impact on the clients seeking (western) medical help only at a later stage of the illness (Egbe *et al*., 2014). This is particularly important for older and less educated clients who take longer to seek help (Ervasti *et al*., 2014) which may prolong RTW, (Lammerts, Vermeulen, Schaafsma, van Mechelen & Anema, 2014).

Not all clients have poor knowledge about mental illness, yet still do not seek early medical assistance. In this instance, poor insight as a form of denial can play a negative role for a client diagnosed with MDD, resulting in them seeking help later only when the condition is severe, (Corbiere *et al*., 2015).

Some clients are reported to assume the sick role which perpetuates the sad affect and low mood thus affecting motivation and therefore, the progress of the client before being considered as stable and improving. This typically results in, a longer period at home in a sick role. Feelings of helplessness contribute to a long absence from work which becomes a barrier to RTW (Millward, Lutte & Purvis, 2005). Low self-esteem in clients with MDD may also delay the RTW process (Lagerveld *et al*., 2012) as most of them doubt their ability to RTW.

The sick role is also affected by “fear-avoidance” where the fear could be based on real or imagined causes. Fear of the unknown, such as not knowing what may happen when returning to work, may result in clients avoiding going to work which also increases the length of their sick leave (Heyland, Hopman, Coo, Tranmer & McColl, 2000) (Dionne *et al*., 2007). Fear related to breach of company rules and regulations prior to admission for an episode of illness, such as absence from disciplinary hearings also delays RTW (Keough & Fisher, 2001). Persons with MDD

fear dismissal and unemployment, which could stem from not understanding company policies when returning to work, outstanding disciplinary processes, or fear of corrective and disciplinary action due to decreased productivity or a long sickness absence with poor communication from the client prior to admission (Keough & Fisher, 2001), (Kennedy, Haslam, Munir, Pryce, 2007). The fear of looking for a job whilst on sick leave may also perpetuate the sick role and delay RTW (Kennedy *et al*., 2007).

It is evident that some symptoms of MDD still exist even after the individual has received proper management for their illness and is considered fit enough to RTW (Schene *et al*., 2007). Fatigue may be under-estimated by some of the clients when they RTW. As a result of a lengthy absence from work, they may have become used to a routine that is less active and cognitively demanding than their work routine, resulting in high fatigue levels (Ross, 2010). Thus work participation may be affected as most permanent employees in South Africa work a maximum of 45 hours per week as set out in the Basic Conditions of Employment Act, No 75 of 1997 (The South African Department of Labour, 1997).

2.10.4 Social Factors

There are multiple psychosocial factors that may prevent the RTW process as well as the duration of sick leave. Esselman *et al*. (2007) reports that the focus of addressing mental illness is shifting from traditional biomedical model of disability towards bio-psychosocial model as proposed by WHO, using ICF as it has been noticed over time that psychosocial factors influence the client's ability to RTW. The psychosocial factors include poor support from the client's family as well as relationship strain amongst the people with whom the client lives. These factors have been reported to affect the length of time preceding the client's RTW (Chow *et al*., 2014).

Financial factors, particularly the inability to take care of household costs and insufficient medical insurance, were amongst the financial factors reported to influence RTW (Kennedy *et al*., 2007). Thoughts of ignorance and stigma still exist towards people with mental illnesses in most South African communities, (Hugo *et al*., 2003), making it difficult for clients to seek appropriate medical care when needed. Stigma and discrimination are also found amongst health care professionals providing care for people with mental illnesses (Egbe *et al.,* 2014), which may increase the risk of non-adherence to treatment, thus affecting the duration of delays in RTW. The beliefs that clients with MDD are weak, pretending to be ill or have been bewitched are also rife and seen in most communities (Egbe *et al*., 2014). These negative ideas impact the client's ability to seek early assistance thereby affecting the duration of RTW.

2.10.5 Work Factors

Successful RTW may be possible with the co-operation of the employer and line manager/supervisor (Ross, 2007). However, clients may have been experiencing stressors at work prior to their diagnosis of MDD, thus making it more difficult for them to be willing to RTW especially if they perceive the stressors as having contributed to their illness (Goldberg & Steury, 2001), (Blank, Harries & Reynolds, 2001), (Okechukwu, Ayadi, Tamers, Sabbath, Berkman, 2012), (Corbiere *et al*., 2015). These stressors may include work overloads, time pressure, the type of work and long working hours (Moen, Kelly & Lam, 2013), (Chow et al., 2014). Nieuwenhuijsen *et al*. (2004) found that supervisor behaviour could also cause a delay in RTW for employees with mental illness. Supervisor behaviour may be regarded as supportive particularly when there is adequate communication between the client and their supervisor (Bender & Farvoldem, 2008). Vemer, Bouwmans, Zijlstra-Vlasveld, van der Feltz-Cornelis and Hakkaart- van Roijen (2013) also added that poor social support from the co-workers also delays RTW time.

Greenspan *et al*. (1996) also found that the client's functional outcome during sick leave may be the predictor of the ability to RTW rather than how severe the injury/illness may be. This was also supported by Millward *et al*. (2005) suggesting that notable improvement in functional outcomes usually means successful RTW, whether it is part time or full time. Research suggests that a client with a vocational case manager also has a higher chance of returning to work due to the support they get from this individual (Millward *et al*., 2005). Occupational therapists can assume the role of vocational case management who is responsible for ensuring the needs of clients and the employer are co-ordinated accordingly (Ross, 2007). Although advantageous, this may be logistically difficult in South Africa due to lack of human resources with a 0.13 ratio of occupational therapists per 100000 people (WHO, 2007), (Burns, 2011).

The relationship between the employer and the employee with an illness/injury is important in the RTW process (Lacerte & Wright, 1992), (Keough & Fisher, 2001). A good working relationship allows the employee to comfortably communicate their needs such as reasonable accommodation, including period of light duty. Reasonable accommodations can also be facilitated by an occupational therapist. Lastly, the relationship between the work demand and the work ability are important as they need to match in order for the client to be able to perform their duties successfully (Chow *et al*., 2014). This is a particular professional skill of occupational therapists. However, whilst much is known about RTW after MDD from a medical perspective (De Vries *et al.,* 2012) , it is the clients' perspective or attitude to RTW that may in fact be the key to a smooth and successful RTW and that it is what is not currently known that needs to be investigated.

2.11 Conclusion

Although RTW has been widely reported, a few studies look at the clients' specific perceptions and experiences which is important when providing a client-centred service. Through a review of the literature, it was found that MDD is a recurrent illness that affects the client, their family and the employer. It is an illness that has an impact on the clients' productivity in their social environment as well as the workplace. It was established through research that many factors may act as a barrier or a facilitator to early RTW as MDD may cause a long absenteeism. A clear gap was identified, in that the clients' perspective was missing. No South African literature regarding this was found. It is essential that occupational therapists have knowledge and understanding about the factors which clients experience to influence RTW, and their relationship to work productivity in order to facilitate intervention aimed at early RTW. The clients' perceptions and experiences are necessary perspectives to view as well as the current vocational rehabilitation conceptual frameworks to ensure that these are included in an existing or modified framework to guide clinical practice. The following chapter will discuss the methodology and the steps taken to perform the study.

CHAPTER THREE- RESEARCH METHODOLOGY

3.1 Introduction

This chapter describes the research methodology that was used to meet the aim and the research objectives of the study as described in Chapter 1. The study was divided into two parts: Part 1 consisted of the qualitative study related to the first two objectives which are to explore the lived perceptions and the experiences of RTW of clients with MDD who have returned to work and to explore the lived perceptions and the experiences of RTW of clients with MDD who have not returned to work. Part 2 was the descriptive study to determine if the results of Part 1 of the study could be included in an existing vocational rehabilitation conceptual framework as whether the framework needed to be modified or re-developed which is objective three of the study.

3.2 Research Design for Part 1

3.2.1 Research Method for Part 1

The researcher used a qualitative method of inquiry in order to examine the complexities and challenges of RTW for clients with MDD from their perspective. A qualitative method of inquiry was chosen in order to explore the concept of RTW from another perspective (Luborsky & Lysack, 2006). A descriptive phenomenological approach was selected to describe and interpret the meaning and understanding of the lived perceptions and experiences of clients with MDD on their return to or delayed RTW (Creswell, 2013). This approach described the structure of the experience and the meaning and perceptions of the experience of the participants from their own perspective, and not from any predetermined set of rules (Bevan,

2014). Thus, participants' experiences were assumed to be known only by them (Kielhofner, 2006). Studying the perceptions and the experiences of the participants regarding the challenge of RTW could only have been done using a qualitative method of inquiry, as these experiences could only be described in words and not by any particular formula or numbers.

A qualitative descriptive methodology was used as the framework for collecting and analysing data in order to gain an understanding of the experience of the participants' personal world of work following a period of medical treatment for MDD (Colorafi & Evans, 2016). This method of analysing data was specifically chosen as the focus is more on a low inference description which does not affect the rigor of the study but rather the amount of reasoning required to make a conclusion of the study from the data collected (Colorafi & Evans, 2016). It is also important to note that this method is useful as the results of the data are always rich description of the perceptions and experiences of the participants (Kim, Sefcik, Bradway, 2017). With healthcare shifting away from using only the medical model, this form of analysis was important in assisting the researcher in gaining an understanding of the factors, other than their medical condition, that influenced RTW from the participants' individual perceptions and experiences (Brocki & Weaver, 2006). This method was chosen as any purposive sampling technique can be used (Colorafi & Evans, 2016) to select the participants that will provide useful data. The use of minimally structured or semi-structured interviews is also acceptable with this method of qualitative study (Colorafi & Evans, 2016). The use of a qualitative descriptive method also allows the researcher to use a conceptual framework to guide the study which can be later changed during the study (Colorafi & Evans, 2016).

Critical to this research was the need for the researcher to put aside all prior knowledge or judgments of 'RTW following hospitalisation for MDD' which is being explored (Lope & Willis, 2014). However, some authors acknowledge that totally disregarding what is already known is very difficult (Elliot, Fischer & Rennie, 1999), as

literature has been reviewed prior to doing the study and the researcher has clinical experience regarding RTW. Thus, it was important that the researcher consciously used the principle of "bracketing" herself in order to fully immense herself in understanding the perceptions and experiences of participants (Elliot *et al*., 1999).

3.2.2 Research context

The study was conducted at Tshepo-Themba Private Hospital in Dobsonville, Soweto, in the south of Gauteng province. It was the context in which the researcher practiced and was therefore a convenient research site. The hospital was one of two private hospitals in Soweto. Tshepo-Themba was easily accessible to the population of Soweto and the surrounding areas such as Roodepoort and Krugersdorp and only 15 minutes away from Johannesburg. The hospital is a general hospital which has 146 beds with private and semi-private rooms, with a dedicated 16 bed psychiatry ward. The hospital also serves clients from neighbouring countries including Botswana and Swaziland as specialist healthcare is subsidised by the governments in those two countries. Private patients that are able to afford health care cost are also seen despite not being covered by medical aid.

3.2.3 Study population

The study population for this research included all clients diagnosed with MDD who are employed, either in a private or a public entity and who had completed the vocational rehabilitation programme while hospitalized at Tshepo-Themba Psychiatric unit. The clients were included in the study if they had had either an early or delayed RTW or have not yet returned to work.

3.2.4 Sample selection

Purposive sampling was used to select participants for this study as the researcher intentionally selected (De Vos *et al*., 2011) typical participants that met the inclusion

criteria of the study (De Vos *et al*., 2011). The type of purposeful sampling that was used was expert sampling in this case the research was investigating the perceptions of clients who had had a period of hospitalisation for MDD and were in the process of transitioning back to work and it is only these selected people (experts) who would be able to report on this (Etikan, Musa & Alkassim, 2016). The strength of this method of sampling lay in the fact that the researcher purposefully selected participants with experience of being diagnosed with MDD and RTW or not, in this case early, delayed or non-RTW after a period of hospitalisation for MDD. The weakness of this type of sampling was the limited generalizability and therefore the results may only apply to clients at this private hospital and may not represent (usually the nature of a qualitative study) the population of clients with MDD in South Africa (De Vos *et al.,* 2011).

This type of sampling was chosen as the researcher could not predetermine how many participants with similar experiences were needed to provide rich information on their perceptions and experience of early or delayed RTW (De Vos *et al*., 2011). In keeping with the qualitative research methodology the sample size was small (Patton, 2002) and no specific number was set for a sample size. However, due to the heterogeneous nature of the clients, it was estimated a minimum of eight to fifteen participants would be interviewed initially to achieve data saturation (Creswell, 2013). Further participants would have been considered if the data were not saturated (De Vos *et al.,* 2011).

3.2.5 Inclusion criteria

The inclusion criteria were designed to ensure that the participants had experience of RTW following a period of hospitalisation and were thus able to provide rich and thick data (De Vos *et al*., 2011).

The participants were required to meet the following criteria:

- between **18 to 60 years of age**,
- have been an in-patient at the hospital diagnosed with MDD by a registered psychiatrist using the DSM-5,
- had attended the occupational therapy vocational rehabilitation programme whilst admitted as an inpatient
- been permanently employed, (government or private) and had a period of time when they were not able to work due to the symptoms of MDD,
- attended their follow up appointments with the hospital's registered psychiatrists.

3.2.6 Exclusion criteria

Clients not included in the study if they were:

- Contract workers as they do not receive the same benefits as permanent employees (such as sick leave benefits) according to the Basic Conditions of Employment Act, Act no. 75 of 1997 (The South African Department of Labour, 1997).
- Clients with MDD and psychosis.

3.2.7 Data collection tools

In this study the data were collected in two ways:

- Demographic data were collected in a self report questionnaire that was designed by the researcher for this specific study (see Appendix A). The demographic questionnaire was developed to explore information about the participants including factors which were reported in the literature to influence RTW (Kielhofner, 2006). This was also to save time and ensure that the interview time was used to collect thick data to answer the research question and the objectives. The demographic questionnaire was completed by the

participants upon arrival for the interview (see Appendix A) and collected information regarding the participants' personal, vocational and health information.

- In-depth, semi-structured interviews were used by the researcher who collected the data in a face-to-face encounter with participants (Brink, 2006). Several studies on qualitative method of inquiry suggested that in-depth face to face interviews were the best method of data collection for a qualitative research such as the current study, which focuses on the experiences of the clients with MDD on RTW (De Vos *et al*., 2011), (Henning, van Rensburg & Smit, 2004) and (Adams, McIlvain, Lacy, Magsi, Crabtree, Yenny & Sitorius, 2002). A semi-structured interiew was selected as it allowed the researcher to choose a number of critical predetermined questions to ask all participants, but there was sufficient flexibility throughout the interview process whereby other questions could ermege (Dicicco-Bloom & Crabtree, 2006).

These predetermined questions guided the direction of the interview rather than dictacting the process of the interview (Brink, 2006). The type of questions used were also phenomenological in nature as they were used to articulate and understand the clients' lived experience (Henning, van Rensburg & Smit, 2004).

One advantage of in-depth semi-structured interviews was that questions could be further explained when not understood by the participants and so that in-depth responses were ensured during the interview (Brink, 2006), (Legard, Keegan & Ward, 2003). In contrast the disadvantages were that in-depth interviews were time consuming and participants were sometimes anxious especially as this process was being recorded (Brink, 2006).

The researcher prepared open-ended questions (See Appendix B) that guided all the semi structured interviews. Some of the questions were relevant for the participants that had returned to work and some of the questions were relevant for the participants that had not yet returned to work. Some of the questions were adapted (See

Appendix B, from question four to eight) during the interview particularly for the participants that had not yet returned to work during the time of data collection.

3.2.8 Data Collection Process

3.2.8.1 Pilot study

Since the quality of the data from an in-depth interview depends on the skill of the interviewer, in this case the researcher (De Vos *et al*., 2011) two trial in–depth interviews were conducted by the researcher with clients who met the inclusion criteria. No videos of the interviews were taken, however, voice recordings were done and reviewed. The interviews were transcribed and the researcher discussed these with her supervisors who recommended changes in the interviewing technique and how the questions were formulated. The purpose of this was for the researcher to gain confidence in interviewing skills and to ensure that thick data were collected (De Vos *et al*., 2011). During the pilot study, the researcher realized the importance of sound interview skills, and as these improved, the researcher was better able to collect rich data. The researcher also recognised the importance of questions with an open-ended structure in order to understand the perceptions and experiences of the participants from their own point of view. The pilot study also resulted in the questions being simplified (see Appendix C) and organized more logically so as to provide a good flow for the interview. However, the results from the pilot study were not included in the final data analysis.

3.2.8.2 Recruitment of participants for the main study

Potential participants who met the inclusion criteria were identified from the occupational therapy records. The potential participants were contacted telephonically by the researcher who invited them to participate in the study. The study information sheet (See Appendix D) was emailed to those who showed interest and those that did not have an email address, collected the information sheet when

they came for their follow-up appointments with the psychiatrist. The information sheet detailed the purpose, aim and objectives of the study, the nature of participation and the time the interviews would take place. They were again contacted telephonically after two weeks to confirm their participation in the study and if they consented convenient time for the interview. The recruitment process took longer than had been planned. Although a number of prospective participants agreed to participate finding a suitable time in their schedule proved to be difficult. Thus the data collection process was completed in an average of six months.

All interviews were conducted in one of the consultation rooms in the Wellness Centre Building at Tshepo-Themba Private Hospital. The consulting rooms used for the in-depth interviews were different to any room used for therapy purposes when the participants were in-patients. This was done purposely so as not to remind the participants about their in-patient therapy experience. English was used as a language of communication during the interviews. The English language was used as a medium of communication as the language is used in the participants' workplace and is well understood by many. Again, the population in Soweto is multicultural and multilingual and therefore speaks different South African languages such as isiZulu, Sesotho, Xhosa, Venda and Tsonga. This would have made it more difficult for the researcher and the participants to communicate and understand each other, therefore affecting the quality of the study.

3.2.8.3 Initiation phase of the interview

The participants were welcomed, reminded of the purpose of the research and asked to sign the two consent forms: to participate in the study and for the audio recording of the in-depth-interview (see Appendix E). They were also reminded of the time (one hour) that had been negotiated for the interview. They were requested to complete the self-administered demographic questionnaire before the interview began, which typically took about 15 minutes. As soon as the questionnaire was completed, the researcher re-established the rapport with the participants that had been built during

their in-patient intervention by giving them an opportunity to ask questions about the research before the interview began. Rapport was built by firstly reminding the participants that what they were going to say was to remain confidential and that they could stop the interview at any time without penalty. Secondly that there will be no judgement imposed to them. Lastly, the participants were calmed down before the interview started by having informal conversations and made sure that they were not anxious.

This initiation phase of the interview was described in the literature as essential to enable participants to feel free to share their experiences in a safe and non-judgmental environment (De Vos *et al.,* 2011).

3.2.8.4 Working/Data Collection phase of the interview

With some of the participants, the pre-prepared questions were asked in a random order but other participants required structure and therefore the questions were asked systematically (see Appendix B). The different communication techniques were used by the researcher to facilitate the data collection process according to her professional judgement of the client's needs (De Vos *et al.* 2011). Non-verbal cues from the participants were observed throughout the interview and no participant cried or asked for the interview to be terminated before its completion.

3.2.8.5 Termination of the interview

Upon completion of the data collection aspect of the interview, the participants were asked if they had any other pertinent information to add before the interview was terminated. The participants that still had information to add to interview were given time to do so and the recording still continued. When no other information emerged from the participants, the interview was reviewed briefly with the client and they were thanked for their participation. They were informed by the researcher that the interview has come to an end and that the recording was stopped.

3.2.8.6 Data saturation

In-depth interviews were continued until data saturation was achieved and no new data emerged (Brink, 2006). Data saturation was achieved after interviewing eight participants and when it was noted that the participants described perceptions and experiences with similar meaning to other participants, without adding anything new. A matrix was used in order to identify the similarities in the responses of the participants to the questions that were used during the interview, (see Appendix F). The inductive content analysis was used in analysing the data.

3.2.9 Trustworthiness

As recommended by Elo *et al* (2014) tustworthiness in this study was considered in all phases of the research namely the prepartaion, organisation, analysis and reporting of the results (Elo, Kaariainen, Kanste Polkki, Utriainen and Kyngas 2014). The following criteria of trustwortiness described by Guba and Lincoln (1989) were used in order to ensure the truthfulness and rigor of the study:credibility (internal validity), transferability (external validity), and dependability (reliability) (Tuckett, 2005).

3.2.9.1 Credibility

The credibility of the study was ensured through the study by:

- Purposefully sampling participants who had been admitted to a psychiatric hospital for the treatment of MDD and who had experience in RTW or in waiting to RTW which was the focus of the study (Tuckett 2005). The participants were also given the opportunity to refuse to engage and participate in the study, which ensured that the people involved are only those that were willing to provide important data for the study (Shenton, 2004).
- Collecting data using in-depth interviews and self-report questionnaires (Creswell, 2013). The researcher had practiced the in-depth interviews in the

pilot study to ensure skill and competence (Tuckett 2005). The interviews were also audio-recorded and verbatim transcripts of the interviews were transcribed. The verbatim transcriptions were audited against the original audio-tape to ensure accuracy which is essential for the systematic analysis which follows (Tuckett 2005).

- Some member checking was planned although the value of this procedure is controversial in the literature. Some authors advocate that members add value in determining the truth when transcripts are returned to them for confirmation (Angen 2000) while others report members have difficulty in remembering and interpreting information over time and the manner in which the information is sent influences confidentiality and interpretation (Sandelowski 2002, Thomas 2016, Carlson 2010). Thus member checking was done during the interview process (Creswell & Miller, 2000), with the researcher clarifying the meaning of the participants' information especially in view of the language used for the interviews (Harper 2012).
- Peer review was also used ensure credibility (Tuckett 2005). Another experienced occupational therapist was asked to review the transcripts of the in-depth interviews and identify emerging themes. These were then compared to the themes that emerged from the researcher's analysis (Creswell, 2013).
- Theory triangulation was also done during the discussion of the findings, and comparison of the emerging themes to the literature and professional theory as well as the existing RTW conceptual framework of another condition (Hussein, 2015).

3.2.9.2 Transferability

Tick description is an essential requirement for transferability (Tuckett 205). The researcher ensured that the study was conducted in a transparent manner. All steps and processes in the study were well documented and decisions taken were recorded. This was done to ensure that another researcher in a different context

(Creswell, 2013) could carry out a similar study. The participants' demographic profiles as well as the research context were described. The data were collected over six months, which ensured that data were thoroughly scrutinised and analysed from the feedback received from the supervisors and the peer review (Tuckett 2005).

3.2.9.3 Dependability

While this study was conducted over a six month period that data was collected in a similar fashion over that time period (Graneheim and Lundman 2003). The participants' demographic data was recorded in a self-report questionnaire and the same questions were asked in the in-depth interviews.

The study has been well documented to ensure that it can be done again (Shenton, 2004).

3.2.9.4 Conformability

The researcher bracketed her knowledge about RTW and was conscious of her biases throughout the data collection and data analysis processes. This was done so that she did not bring predetermined knowledge and judgements to the interviews. This was continued until the data analysis was complete to prevent biasing and influencing the participants (Creswell, 2013).

3.2.10 Ethical considerations

The study was approved by the Faculty of Health Science's Graduate Studies Committee. (See Appendix G) and ethical clearance was granted by the Human Research Ethics Committee (medical) (See Appendix H). Permission was requested and received from the manager of the Psychiatric unit Tshepo-Themba Private Hospital (See Appendix I). The owner of the occupational therapy practice, also granted permission for the study to be conducted (See Appendix J).

The following ethics were also considered and adhered to during the in-depth interviews used to collect data during the study (Kielhofner, 2006):

During the interviews respect was shown to participants at all times. Respect of the participants was ensured by providing comprehensive information to the participants regarding the study so that they could make a considered autonomous decision to participate or not. Prior to the interviews the researcher acknowledged she was a post graduate student and was learning from them. The questions asked were carefully selected so as not to cause any psychological distress. If this were to happen, the researcher would have been empathetic and contained their feelings, before finding out which psychologist they would prefer to be referred to.

The researcher ensured that the interviews were terminated at the time agreed upon as some of the participants had attended follow up appointments and needed to go back to work.

The right to privacy was upheld by ensuring that the participants had full knowledge that the interviews were audio-recorded to assist with the analysis. Due to the nature of the study (qualitative study), total anonymity and confidentiality were ensured through the use of codes instead of the participants personal details and the researcher did not call the participants by their names during the recordings.

The participants were informed that only the co-coder and the supervisor would have access to the interview data. Professionals will be able to access the results of the study once it is published, but no person will have access to participants' personal information and the interview information.

Participations were not coerced to participate in the study. The researcher ensured that participants knew that they had the right to decide whether they participate in the study or not. This was done by the use of information sheet and participants could ask for clarification at any point when they did not understand. Participants that had

agreed to participate were given two informed consent forms (one to agree to participate in the study and another to be audio recorded) to sign as evidence that they had agreed to participate in the study. Participants were informed that they may withdraw at any time without detriment to themselves (Brink, 2006) and this was also included in the information sheet.

3.2.11 Analysis of the Interview

3.2.11.1 Demographic data analysis

The demographic information of the participants was analysed first and demographic statistics were used to describe the central tendencies: means, modes and frequencies. Demographic data were described using a table and all the information of the participants was included.

3.2.11.2 Descriptive analysis

The interviews recordings were changed into an MP3 file and saved onto a memory stick that was only used to store the audio clips. The MP3 clips were professionally transcribed verbatim, however, the researcher still had to listen to the clips and ensure that the transcription was correct and reflected meanings and perceptions expressed by the participants. Data were analysed manually and the researcher then started with the analysis of the in-depth interview using the steps of inductive content analysis as a guide to analyse the data collected (Elo & Kyngas, 2008). Data analysis was done in three phases according to Elo & Kyngas (2008), however, two phases were done in Part 1 and the last phase was done in Part 2.

a. Preparation phase

- **Reading transcripts**

  During this first step, the researcher read the transcripts a number of times to immerse herself in what the participants are saying. The researcher noted

significant words or statements that emerged on the left margin and also identified the participants' experiences versus their perceptions.

- **Paraphrasing the verbatim**

  Secondly, the researcher paraphrased what was said**.**

b. Organising phase

- **Identify themes**

  Thirdly the researcher identified themes that emerged by identifying similar ideas/ connections and attempted to make sense of these connections.

- **Matching themes**

  Fourthly the researcher clustered the themes and matched them to what the participants had said. The researcher started looking for extracts of what the participants had said to match the themes that had emerged.

- **Creating a list of themes, codes and sub-codes**

  Lastly, the researcher then created a table listing all themes, codes and sub-codes that emerged from the data. This method is helpful in data that will be used in practice for health care research (Bradley, Curry, Devers, 2007).

3.3 Research Method for Part 2

The purpose of Part 2 was to ensure that the clients' perceptions and experiences of their RTW following a period of hospitalisation and absence from the workplace due to an admission for MDD were accommodated in the rehabilitation process. To do this early identification of vulnerable clients is required, as well as being able to provide appropriate support for the RTW process and specific intervention for job retention and vocational rehabilitation relevant to the South African context if this is needed (James, Cunningham, Dibben, 2003).

3.3.1 Method

The method used in Part 2 was an extension of the descriptive qualitative method used in Part 1 (Colorafi & Evans, 2016). This method was used by the researcher to guide analysis of the results which emerged from Part 1 and compare them to an existing RTW conceptual framework for cancer survivors. Thus Part 2 of the study also included the modification/adjustment of the conceptual framework in the light of results of the current study (Colorafi & Evans, 2016).

A conceptual framework was used in this Part 2 of the study to provide structure for the interlinking of factors which were perceived by clients to be significant in their RTW process following a period of hospitalisation for MDD. A conceptual framework adds value in understanding the inter-relationships between the ontological (the reality of concepts), epistemological (how things are perceived by the clients) and methodological (how they work) roles of the factors identified by the participants (Jabareen 2009). These factors are built into a framework which considers the inter-connectedness of the factors so that they can be used to guide the RTW vocational programme offered at the research site.

While the literature has not defined a specific qualitative method for developing a conceptual framework, Jabareen suggested a number of steps that can be followed to develop or modify a conceptual framework which will be discussed in the research process that was followed (Jabareen 2009). Qualitative content analysis which was applied in Part 1 was used again in Part 2 of the study (Kim, Sefcik, Bradway, 2017).

3.3.2 Research process

The process of developing a conceptual framework described by Jabareen in 2009 was adapted for comparing the elements or components of the conceptual framework for the cancer survivors by Chow *et al*. (2014) and was compared to the results that emerged from Part 1 of the study.

- Identifying and naming concepts,
- Deconstructing and categorising the concepts,
- Re-integrating the concepts,
- Synthesis, resynthesize and making it all make sense (Jabareeen 2009).

3.3.3 Data analysis

Data were analysed according to the last phase of the content analysis process. This entailed that the researcher needed to have first prepared and organised the data. The last step was to report the analysis process and the results (Elo & Kyngas, 2008). In this phase the results were first analysed by firstly comparing them to the existing conceptual framework by Chow *et al*., 2014 and lastly reported by modifying the existing conceptual framework for clients with MDD.

3.4 Conclusion

The researcher used a qualitative method of inquiry in order to answer the research question and the study objectives. The researcher abided by the ethics governing the research and ensured that the participants' rights were protected at all times. In Part 1 a descriptive qualitative method of approach was selected and used in order to describe the participants' lived perceptions and experiences of RTW. Finally a qualitative content analysis was used to explore the data that were received from the participants. In Part 2 the results were further analysed to determine the goodness of the fit (through highlighting the similarities and the differences) with the conceptual framework described for the RTW of cancer survivors reported by Chow *et al*. 2014 to that of the clients with MDD in the current study. The analysis was to ensure that the conceptual framework was to be modified in order to fit RTW for clients with MDD. The following chapter will highlight the results from Part 1 and Part 2 of the study.

CHAPTER FOUR: RESULTS

The results of this study will be reported in two parts. Part 1 will report the qualitative findings of the in-depth interviews dealt with in objectives 1 and 2 and explored the participants' perceptions and experiences of RTW following a period of hospitalisation. Part 2 will relate the findings of Part 1 to the conceptual framework developed by Chow *et al*. (2014) for RTW for cancer survivors.

4.1 Results from Part 1 of the study

4.1.1 Demographics of the participants

Eight participants took part in the study, 75% (n=6) were females and 25% (n=2) were males (See Table 4.1). All the participants were Africans and while their home languages ranged between Sesotho, Setswana, Zulu and Xhosa they were all fluent in English, the language in which the interviews were conducted. The participants were all classified as middle class according to their types of occupation. All participants were compliant with their post hospitalisation care and continued attending their follow-up appointments with the multidisciplinary team including the occupational therapist.

As can be seen from Table 4.1 the ages of participants ranged from 25-46 years. The average age of the participants was 34.5 years. Only two of the participants were married, five participants had children (between 1 and 3 children) but all participants had people at home for whom they felt responsible. Six of the eight participants had RTW at the time of the in-depth interviews.

Table 4.1: Demographic characteristics of the participants (n=8)

NAMES	AGE	GENDER	MARITAL STATUS	NO. OF CHILDREN	PEOPLE IN THE HOUSE	RETURNED TO WORK
1	26 yrs	F	Single	1	Fiancé	**YES**
2	27 yrs	F	Single	1	Grandmother and son	**YES**
3	37 yrs	M	Married	3	Wife and children	**YES**
4	44 yrs	F	Married	2	Husband and children	**YES**
5	32 yrs	M	Single	0	Fiancé	**YES**
6	39 yrs	F	Single	2	Mother, children and brothers	**YES**
7	46 yrs	F	Single	0	Mother and sister	**NO**
8	25 yrs	F	Single	0	Grandparents and brother	**NO**

Table 4.2 reports that all participants had completed secondary school and had achieved a national senior certificate. Seven of the eight participants had additional education ranging from a higher diploma to a bachelors level qualification. Those who had additional qualification seem to have gained their first job earlier than one participant who only had a grade 12 education level. All participants worked to gain finances to care for significant others or improve their life. None of the participants were shift workers however their work hours per week of the participants ranged from 35 hours to 65 hours. Only two participants used their own cars to travel to work whilst the six other participants used public transport which included a taxi or a bus.

Table 4.2: Participant's educational and vocational information (n=8)

NAME	TERTIARY QUALIFICATIONS	AGE OF FIRST JOB	TYPE OF WORK	DISTANCE TO WORK	WORKING HOURS/WEEK	REASON FOR WORKING
1	Higher certificate	20	Service agent	33 km	37.5hrs	"Provide for family"
2	Higher certificate	21	Office admin	13 km	35hrs	"To make a living"
3	Diploma	20	DTP operator	45 km	45hrs	"To look after my family and extended family"
4	Higher certificate	22	Data capturer	5 km	40hrs	"To support the family"
5	Diploma	21	IT specialist	45 km	45hrs	"Making a living"
6	Higher certificate	20	Office admin	24 km	50hrs	"Making a living, taking care of family, having a better life"
7	None	32	Service consultant	20 km	40hrs	"To support mom"
8	B Tech	22	Site engineer	58 km	65hrs	"Double shifts and supervision"

All the participants were diagnosed with MDD as per the inclusion criteria of the study. Six of the participants were diagnosed in the admission prior to the data collection whilst the other two participants were diagnosed more than two years ago (See Table 4.3). Seven the participants had reported to be adherent to their medication however this was contradicted during interviews when two participants reported to have stopped taking the medication. At the time of data collection, two participants had not yet returned to work which indicated that they had the lengthiest sick leave as compared to other participants whose sick leave ranged from one to two months.

Table 4.3: Health information of participants (n=8)

NAME OF PARTICIPANT	DATE OF DIAGNOSIS	DURATION IN HOSPITAL	ADHERENCE TO MEDICATION	DURATION OF SICK LEAVE
1	March 2015	2 weeks	Yes	2 months
2	February2015	3 weeks	Yes	3 months
3	October 2003	2 weeks	Yes	2 months
4	April 2015	3 weeks	No	2 months
5	January 2015	3 weeks	Yes	3 months
6	June 2010	3 weeks	Yes	2 months
7	March 2015	3 weeks	Yes	4 months
8	May 2015	3 weeks	Yes	2 months

4.1.2 In-depth Interviews

Below is Table 4.4 that highlights the themes, codes and sub-codes that emerged from data analysis of the in-depth interviews of the eight participants that took part in the study. Two themes emerged whilst there were three codes that emerged from the each of the themes.

Table 4.4: Themes, codes and sub-codes

THEMES	CODES	SUB-CODES
Waiting to RTW **(Objective 1)**	Ruminating about RTW	Reluctance to RTW Concerns about work politics Job contributing to illness
	Fears about RTW	Chances of relapse Not coping on RTW
	Social pressure to RTW	Meeting financial needs and responsibilities
Perceptions and Experiences on RTW **(Objective 2)**	Attitudes of colleagues on RTW	Stigma of mental illness Personal and work support
	Work demands on RTW	Need for work accommodation Lack of work satisfaction
	Residual symptoms on RTW	Fatigue Poor concentration

4.1.2.1 Theme 1: Waiting To Return To Work

This theme describes the participants' perceptions and experiences of clients who have not returned to work. This theme represents the time that participants had been at home prior to RTW. In keeping with managed health care, medical aids usually only fund a three week period of hospitalisation and most of the participants had been admitted for the full three week period. After the participants' were discharged from hospital most psychiatrists prescribed an additional period of sick leave, as the psychiatrists were of the opinion that the participants were not yet ready to RTW. As

can be seen in Table 4.3 this additional sick leave varied from three weeks to four months.

Seven of the participants were interviewed six weeks post their discharge whilst one participant was interviewed eight weeks post discharge. This period of additional sick leave was viewed by all participants as essential to their recovery period. However, the participants indicated that this recovery period while they were waiting to RTW was troubled.

"The weeks that I was at home, it was hard. I was always yawning. I was so tired. I was exhausted. I could not even drive, and I had things to do [but I could not do them]. I could not understand what was going on with me. I could not even sleep" [P8].

This feeling of being troubled was reported to be mainly due to concerns about their job security and the communication that they received from their managers, colleagues and human resource personnel, questioning the duration of their sick leave and when would they RTW. One of the participants reported:

"Well, ok, they phoned me. I remember when they told me that I had to come back to work [now]" [P7].

Three codes were identified within the first theme (see Table 4.5), and these are ruminating, fears and pressure to RTW.

Table 4.5: Theme 1

	Codes	**Sub-codes**
Waiting to RTW **(Objective 1)**	Ruminating about RTW	Reluctance to RTW Concerns about work politics Job contributing to illness
	Fears about RTW	Chances of relapse Not coping on RTW
	Social pressure to RTW	Meeting financial needs and responsibilities

4.1.2.1.1 Ruminating about return to work

The nature of MDD is that it perpetuates negative thoughts especially when issues have not been adequately resolved (Moore, 2015). Thus, encouraging the client to continuously and unconstructively brood on and agonise over issues that bother them. The participants had many issues that were still bothering them but common amongst all the participants were thinking a lot of the unresolved work issues and the contribution that work had played in the development of their illness and their subsequent diagnosis. The quote below is an example of the thoughts that the participant was overthinking about when during their sick leave.

"To a big extent, [work contributed to illness] especially my recent position now. Because the pressure is too high. The workload is too much. The expectations, obviously from the powers that be and also I don't want to call it passing the bar, but I want to say that some of the admin ladies that are there, I have assumed their roles" [P6].

Participants were preoccupied, thinking a lot about their imminent RTW and that these thoughts were mostly negative.

"I think a lot and not only about [work], mostly about bad things and not good things. Both the work and the pressure. If it was the work alone it was fine because I would find ways to deal with it. But when there is someone [manager] involved in putting too much pressure on you, you end up not knowing what to do" [P2].

"I was thinking about so many things, like killing myself or just disappearing. There are so many challenges [at work] [despite this] I really like my work." [P7]

During data analysis three sub-codes associated with the code ruminating were identified. These represented the common issues participants were ruminating about. Each of these three sub-codes will now be described.

4.1.2.1.2 Reluctance to return to work

Some of participants stated that they did not want to RTW, explaining it was not that they did not want to work but they did not wish to return to place that they had worked before. This reluctance was also observed in their facial expression when they were expressing themselves while discussing RTW and the ongoing issues thereof. This suggests that they were persistently thinking about these issues prior to their RTW.

"I would prefer to go somewhere else, start afresh."[P1]

"On Sunday before I went back to work, I thought I don't want to go back there [work]."[P6]

"….If I didn't have the child to support, I would not have gone back" [P4].

4.1.2.1.3 Concerns about work politics

The politics at work were reported to be one of the factors that participants identified as contributing to their reluctance to RTW. Even though the participants come from different work backgrounds, six of the participants experienced work politics. These

work politics were described as negative but were specific to each participant's specific work environments.

"There is a lot of nepotism at work I was the only person that got there [got appointed] without knowing someone or having worked with anyone else within our division. So everyone is someone's cousin, it just does not work honestly" [P8].

"*If you do not know your rights there [at work] and you cannot speak for yourself, then you are in trouble. I think if we [were managed] by public service managers and [not] police service managers, there was going to be a balance. Our managers are all police officers and so they still use that strategy for policing [aggressive]. There are no team building [activities] or entertainment. If you ask for a half day, it is like you have asked for the whole week" [P4].*

4.1.2.1.4 Job contributing to illness

Whilst participants were still at home the constant rumination also made them think negatively about their work environment and how the work issues experienced have also contributed to their illness.

"So um….my job [that] did I can easily say that ja my job did play a role in it [diagnosis]" [P5].

Participants reported varied aspects of the job as having contributed to their illness such as the position that they held and the job demands:

"To a big extent, especially my recent position now" [P6].

"Yes, I was working late every day when I started having the problem [depression] [P3].

"I can say I think that 40% has contributed because we are short staffed' [P4]

It was therefore observed that the much of the time that the participants spent at home during their sick leave was on ruminating about work issues that were perceived to contribute to their illness. The next code describes the fear that the participants experienced when they were awaiting RTW.

4.1.2.1.5 Fear about return to work

The experience of fear amongst the participants is described in this second code of the first theme. Fear mostly related to job security, the period of absence and uncertainty about what would happen upon RTW.

Most of the participants' employers were only informed about the additional sick leave that was given by the psychiatrist and its duration after the participants were discharged from the hospital. All of the participants in the study are permanent employees as specified by the inclusion criteria and therefore, all of the participants are entitled to a three year leave cycle of 30 or 36 days, depending on whether they have a 5- or 6-day work week. But due to the nature of MDD, the participants could have experienced symptoms long before the diagnosis was made and may have had considerable time away from work.

"I was speaking to my partner [before] and I was feeling emotional always, always down. I thought I should speak to a therapist or psychiatrist or whatever. There was an idea that I am depressed but never thought it would come to this stage" [P1].

If the participants were experiencing symptoms for a period before admission to hospital, it may imply that they might have already taken considerable time off work. While the long sick leave can be advantageous to their recovery, it can also increase or make the participants develop serious concerns about their job security, as well as the process of RTW.

All participants expressed the fear of not knowing what to expect when they RTW as the issues experienced prior to admission had not yet been addressed.

"I suppose also the fear of not knowing how the division [department] works in terms of people being away for months, for so long and what their HR requirements are. If they would actually have a welcoming environment for me when I returned" [P6].

"Actually, I did not have any expectations but my fear was that I had to go back to work….nothing has been done [during the time I was sick]" [P4].

4.1.2.1.6 Fear of chances of relapsing

The participants had different views/perceptions of what made them fearful about RTW. Some participants reported that they feared not coping with the work demands when they RTW:

"Like my challenges and my fears were if I was going to be able to do what she wants me to do" [P2].

"So I was worried [about] how was I going to cope with the system, looking at the computer for more than four hours every day" [P4].

4.1.2.1.7 Fear of not coping on return to work

While other participants feared relapsing by returning back to the very same environment that had contributed to their illness and diagnosis of MDD.

"I didn't want to have a breakdown or relapse" [P2].

"….So I think I carry that fear every day that um…I'm gonna go through the same thing that I went through you know and that I'm gonna go to the hospital again" [P5].

Firstly it appeared that the participants were not aware of their conditions of service especially when it came to long sick leave. Secondly the participants did not appear to communicate with their HR representatives regarding improving knowledge on the conditions of sick leave thus perpetuating concerning feelings about their sick leave which could have been avoided.

The next code will be looking at the press to RTW. This was of particular interest as the participants had all experienced negative thoughts about RTW.

4.1.2.1.8 Social pressure to return to work

This is the third and last code of the first theme. This code described an interesting experience of the participants. Even though participants felt that they did not want to RTW, they reported that they felt pressured to RTW.

"So I just had to [return to work]" [P2].

Financial concern was the single sub-code identified. It was clear from the demographic forms (See Table 4.1) that all the participants had financial responsibilities to fulfil and had family members or other significant others to take care of. Financial independence and being able to take care of once needs was important to the participants. It was noted that this was a strong driver to RTW in spite of the participants' fears and misgivings about the job they held and the extent to which they felt it contributed to their illness:

"Working is a big part of living and working is a big part of being able to be independent and not depend on other people to feed you, clothe you" [P6].

"I had to work and make a living for my child" [P2].

"Honestly, firstly it was looking after my family. If I do not work, my family is going to suffer" [P3].

The first theme highlighted both the participants' perception of RTW and their experiences of awaiting RTW. These were predominantly both negative and it appeared that this period was very difficult for the participants.

The second theme described the experience of RTW for the six participants that had returned to work at the time of data collection.

4.1.2.2 Theme 2: Perceptions and Experiences of return to work

The second theme that emerged from the data analysis was the experiences of the participants when they RTW as described by six out of the eight participants who had returned to work at the time of the in-depth interviews. Thus, six participants had a first-hand experience of RTW. Due to ongoing rumination about work described in Theme 1, the negative perceptions as well as the anxiety these negative thoughts elicited, most of the participants were apprehensive about their RTW. However, participants' descriptions of the actual experience were mixed: While for some of the participants' experience was negative,

"I thought I had sorted things out with my family and all that and again work, the negativity [at work], I could not handle it, it was becoming too much. I just got emotional, I had breathing problems. Then I had a panic attack" [P1].

Others reported their RTW experience was more positive than they had expected as is evident in the following quote:

"I was a bit concerned because when I was in hospital I kept getting calls about work, about when I am returning [to work]. So I was a bit concerned. I was wondering how things are going to play out that day. But when I got to work I found that most people were concerned as in truly concerned. And HR, the first step they took was to have a meeting with me and find out how they can help me. Even though not much came out of it but at least it was a positive start" [P6].

The participants described very different work environments to which they were returning which had some influence on their experience such as an: insurance company, private school, construction company, marketing business, the bank and a government department. In spite of these differences participants described either the physical or social structures as challenging.

For some participants it was the physical work context that was the most challenging as suggested in the following quote:

"The first day, it was very stressful. It was because of the noise levels and where I sit is next to the entrance. I spoke to my team leader and it happened that I had a panic attack. So I could not cope. It was very strenuous" [P1].

Whereas for others it was the social structures including the size of the company and the number of employees as well as the different responses/attitudes of the co-workers to the participants with MDD that was most challenging.

"I don't know if I should say I was scared or what. But I was not looking forward towards [going to work]. Even [if] my colleagues were happy to have me back. They welcomed me they asked me how I am doing. But she [the boss/manager] was just being as pretentious as always. So at some point [after my interaction with her] I felt like not going back at all" [P2].

In this 2nd theme three codes were identified (see Table 4.6): attitudes of colleagues, work demands and the residual symptoms. Under each of these codes sub-codes were identified in the analysis and will be reported in detail in the section below.

Table 4.6: Theme 2

	Codes	**Sub-codes**
Perceptions and Experiences on RTW (Objective 2)	Attitudes of colleagues on RTW	Stigma of mental illness Personal and work support
	Work demands on RTW	Need for work accommodation Lack of work satisfaction
	Residual symptoms on RTW	Fatigue Poor concentration

4.1.2.2.1 Attitudes of Colleagues on return to work

This first code of Theme 2 emphasised the importance of the social context of work as well as successfully negotiating the interpersonal challenges after a mental illness. Due to varied beliefs that work colleagues hold about mental illness and experiences of mental illness, co-workers often have difficulty in knowing how to approach and interact with a person who has suffered an episode of MDD. The participants reported varied experiences of the attitudes of both the colleagues and supervisors towards them on their RTW. Some of the participants reported positive attitudes from their colleagues:

"Well my colleagues I just felt I don't want to be treated like a king. I don't want them to be asking me: 'are you sure you are fine'. I just thought I want life to continue normally. But obviously because I was not there for a long time. I kind of understood where they were coming from. Like they just wanted to show me that they cared" [P2].

Other participants described negative attitude towards them upon their RTW.

"There were people that were happy that I was back and there were people that were pretending. For instance, like I said there were some of them who wanted me to get fired. They talk bad when I did not do anything wrong" [P1].

4.1.2.2.2 Stigma of mental illness

Stigma was the first of the sub codes identified. Mental illness is not visible to the naked eye and all participants perceived that stigma is experienced when a person discloses their illness. Stigma was perceived by participants as being both internal and external. Many people with mental illness have internal stigma seeing themselves as weak and incapable whilst others experience stigma from their families, co-workers or the community at large. People with mental illnesses, including MDD, get called terrible names because they are diagnosed with a mental illness. No one participant described experiencing stigma per say although most described the perception of negative talk about themselves on their RTW.

"Also I think I was more worried about the stigma that goes with people who have such issues [MDD]. I have noticed that some people would not outwardly admit that they [suffer from] depression or stress disorder or whatever, only because they are afraid of being judged by other. People look at you and think yeah, she is not in control, she is just not strong enough, or she is a mental case" [P6].

"So I still am feeling probably like an out-cast everybody [is] feeling sorry for me, like oh the poor guy he can't take stress you know. He can't deal with stress you know". [P5]

4.1.2.2.3 Personal and work support

Participants all reported that in their view support from management and colleagues was important as it could assist them to ease back to the job seamlessly without any difficulties and to re-establish the sense of belonging which had been negatively

influenced by the symptoms of MDD. The participants expressed different views regarding what 'support' meant to them. Some expected both colleagues and supervisors to be more understanding, to acknowledge their illness and suffering through their interaction, whilst others expected a change in their working conditions, which included decreasing their workload. However, most participants reported that they did not receive the 'support' that they expected which made their RTW difficult especially to re-establish their worker role within the working environment.

Those participants that perceived that they did not receive the 'support' they expected described feeling that they had not coped well during their initial RTW.

This sentiment was evident in the two quotes recorded\ below:

"I expected him [boss], on the first day when I came back to the office to say 'are you sure you want to be here you know, don't you want more time or something like that type of a thing. And I am not saying you know I needed more time or anything like that but you know those things to me would have shown the support and understanding of what I am going through" [P5].

"My first day at work was not that easy. My chief commander is somebody who says work is work. So the first day I went to work, he didn't even ask how am I, will you cope or what. I was just given work immediately" [P4].

On the other hand there were those participants that believed that they received the support they needed, perceived that they coped better than expected when going back to work:

"My colleagues were also very supportive, come to think of it. And they also now more than ever they've started sharing also how they feel and that I shouldn't get so overwhelmed because they also feel like that sometimes" [P6].

"All I know is that my team leader was very happy to see me. She said I must take it easy. I mustn't just do what I usually do and take all the breaks and all that" [P1].

It appears that support (although perceived and understood in different ways) was important to all the participants in facilitating their smooth transition back to work. However, some participants did not receive the support they felt they needed making it difficult for them to adapt to the work conditions again and reconsider their readiness to RTW.

The following code identified in this theme describes the participants' experience of their work demands.

4.1.2.2.4 Work demands on return to work

The second code that emerged from data analysis was work demands. This code primarily dealt with the contents of the job and the demands that were made on the participants by their colleagues or supervisors on their RTW. The participants had very different types of jobs which demanded different levels and types of skills, however all jobs were familiar and all participants reported having done the job competently before their episode of MDD. Nevertheless, participants reported experiencing the conforming to or complying with the demands of their jobs differently on their RTW. Most felt it was easy to perform some of their work tasks as there was support from the colleagues and supervisors, whilst others felt that the workload which they perceived to have contributed to their illness had stayed the same and was high.

"In my first two weeks of going back to the office, I literally did not get any work because everybody felt that I was too fragile to give me work. So in that manner I did not have any pressure of time to deliver. I think that helped me to get back to my feet" [P5].

There were two sub-codes that emerged from the area of work demands that the participants described. These two sub-codes tie in to the experience of performing work demands, challenges and the support thereof experienced at work.

4.1.2.2.5 Need for work accommodation

Work accommodation after a long absence from work due to an illness is expected. Reasonable Accommodation is a principle within the Employment Equity Act 55 of 1998 and the Code of Good Practice, provided that the participants disclose their illness to their employer and request accommodation. While participants reported that they feared and were reluctant to RTW and felt concern about being able to cope with the workload, it was reported that accommodation of work load was available on request by either the participants or by the occupational therapist on behalf of the participant. Although not directly expressed, the participants reported a need for work accommodation that entailed them receiving limited work tasks within the first two weeks of their RTW, but that the number of work tasks was slowly graded up to their original work load.

"I remember when I came out of hospital the very first day I went back to work I set up a meeting with my line manager and with HR also. I sat down with both parties in separate meetings and I made them aware of my state of health and the concerns I had within the company and how the environment at work continues to take me to hospital. So the first day turned out better than I had expected, because people were going out of their way to try and help me settle in" [P6].

The results also indicated that some of the participants did not receive any work accommodation as a RTW meeting was not held and subsequently no work accommodation issues regarding work performance were discussed and the participants had to continue with their normal work duties. These participants also reported a high work load before admission and after their sick leave when they RTW. The participants that reported that this occurred because they were either the only

workers that held this position and could do that particular work or there was poor human resource management such that even when one employee is off sick, it is difficult for the rest of the team (despite knowing the work) to take on and perform all the work tasks of that employee. Lack of the necessary resources to do a particular job also influenced work load.

"When I got there [back to work], I was doing the quantity surveyor's work. I was doing the contract manager's work [and] I was also doing my own work. I was doing the government's work. I was doing everyone's work. I then told them to give me software because it was a bit strenuous for me to work without any software. I had to deliver the work even though there were no resources" [P8].

4.1.2.2.6 Lack of work satisfaction

It appeared that due to the ongoing issues at work, five of the participants had poor motivation which in turn has resulted into poor work satisfaction**.** These work issues also included poor growth and development at work. This was not only experienced by the participants that had RTW, but was feared by those who had not yet returned to work.

"I feel like I try so hard and yet she is still not satisfied, and I am also unhappy in that process. Because with your job you are supposed to be happy but I am not" [P2].

"I would prefer to go somewhere else, start afresh. Or do something different, something more challenging, I have been doing this for the past five years and I see no growth in it" [P1].

"And then when you have a team that is also not supportive when it comes to growth and also people that try and hinder your growth, that is not good" [P8].

There were only two sub-codes that emerged from the work demand code. There were clearly varied experiences of RTW seen amongst the participants in the study.

The next code describes the residual symptoms participants experienced upon RTW which influenced their ability to work efficiently and effectively.

4.1.2.2.7 Residual symptoms on return to work

Recovery from an episode of MDD takes time and some symptoms persist long after the mood has lifted. Participants reported the experiencing of ongoing symptoms long after discharge from a period of hospitalisation and before and after returning to work that affected their performance in most occupational performance areas. Such residual symptoms included fatigue, lowered motivation and energy, feelings of pessimism, poor concentration and memory as well as reduced ability to make decisions and problem solving. The last code identified in the experience of experiencing residual symptoms with the most common being fatigue and poor concentration which were the two sub-codes that were identified.

4.1.2.2.8 Fatigue

The participants were interviewed post discharge which is thought to be their final stage of their treatment. They were predominantly in their ninth week of taking medication and their acute symptoms had mostly settled. The participants reported a less rigorous routine to that of being in the hospital but being at home made it difficult to adjust to their typical working environment. Associated with this was the requirement to wake up early, travel to work and be productive when they got to their workplace. Whilst they were on sick leave, there was also little expectation from those around them.

"Those [first] two weeks were really about getting myself into a state of mind and making my body get used to waking up and being physically alert [to go to work]. So I had to take it slow a bit but as the days went by my body got back into the routine of working. I still need to sleep more. Some days at the office also I find that I get tired very quickly" [P6].

"Because mind and body is already used to that relaxation and am getting back to the noise from the kids, they are up and down in the office and the parents. Phone [is] ringing all the day. It was difficult" [P2].

4.1.2.2.9 Poor concentration

All the participants reported difficulty with concentration and focusing on the tasks that they were doing prior and after RTW. There were varied views about the causes of poor concentration amongst the participants. Some felt that it was due to the side-effects of the medication, others felt it was because there were still existing stressors that they needed to be resolved and they were still thinking about (both at home and at work).

"So I can't in a way concentrate or do my job properly or enjoy what I'm doing despite the fact that I love doing my job. It is [the] people surrounding me [at work] that are negative and all that" [P1]. "Yeah, like the concentration is the problem, I must take it slow. If I am tired I must leave, I must not work I must take a break……Like since you know my finances was a problem. I had to discover that my daughter, her fees for one month were not paid from admission to going to Durban. Most of the debts were not paid" [P4].

"So as I said I mean I have to sit at my desk for eight hours now and I haven't been at work for a very very long time. So the first two weeks were very had because it was difficult to concentrate for that long..." [P5].

It is clear that despite being given time away from work due to an illness such as MDD residual symptoms may affect work performance.

4.1.3 Summary of the results of Part 1

The results that emerged from the data analysis highlight the perceptions of all eight participants on RTW whilst still on sick leave and the experiences of RTW which are indicated in Table 4.1 for six of the participants that had returned work and the remaining two that had not yet returned to work at the time of the in-depth interviews. It is clear from the results that the period in which the participants were waiting to RTW was not as conducive to their recovery as was hoped as they had concerns and some negative expectations of the RTW process and the experiences of negative symptoms which are the fears on RTW, social pressure to RTW and persistent negative thoughts about RTW (ruminating). For those that had returned to work, some had positive experiences whilst others had negative experiences which again highlight the different experiences of the participants. The results also indicated that there were no clear differences in perceptions and experiences that emerged between the participants that had returned to work and those that had not.

However, some of the participants had a positive experience of RTW due to supportive colleagues and the reasonable accommodation that was provided to them. Other participants did not report a good experience of RTW as there were still ongoing unresolved work related issues that persisted even after the long sick leave. Despite low work satisfaction and reluctance to RTW, the participants had a financial pressure to RTW which did not allow for changing jobs even if this was desired. The researcher has designed a diagrammatic representation of the different factors that influenced RTW for clients with MDD. Below is Figure 4.1 which shows that the process of RTW for clients with MDD is influenced by many factors, some were identified in the RTW conceptual framework for cancer survivors by Chow et al. (2014) and some are unique to MDD and will be discussed in the following chapter.

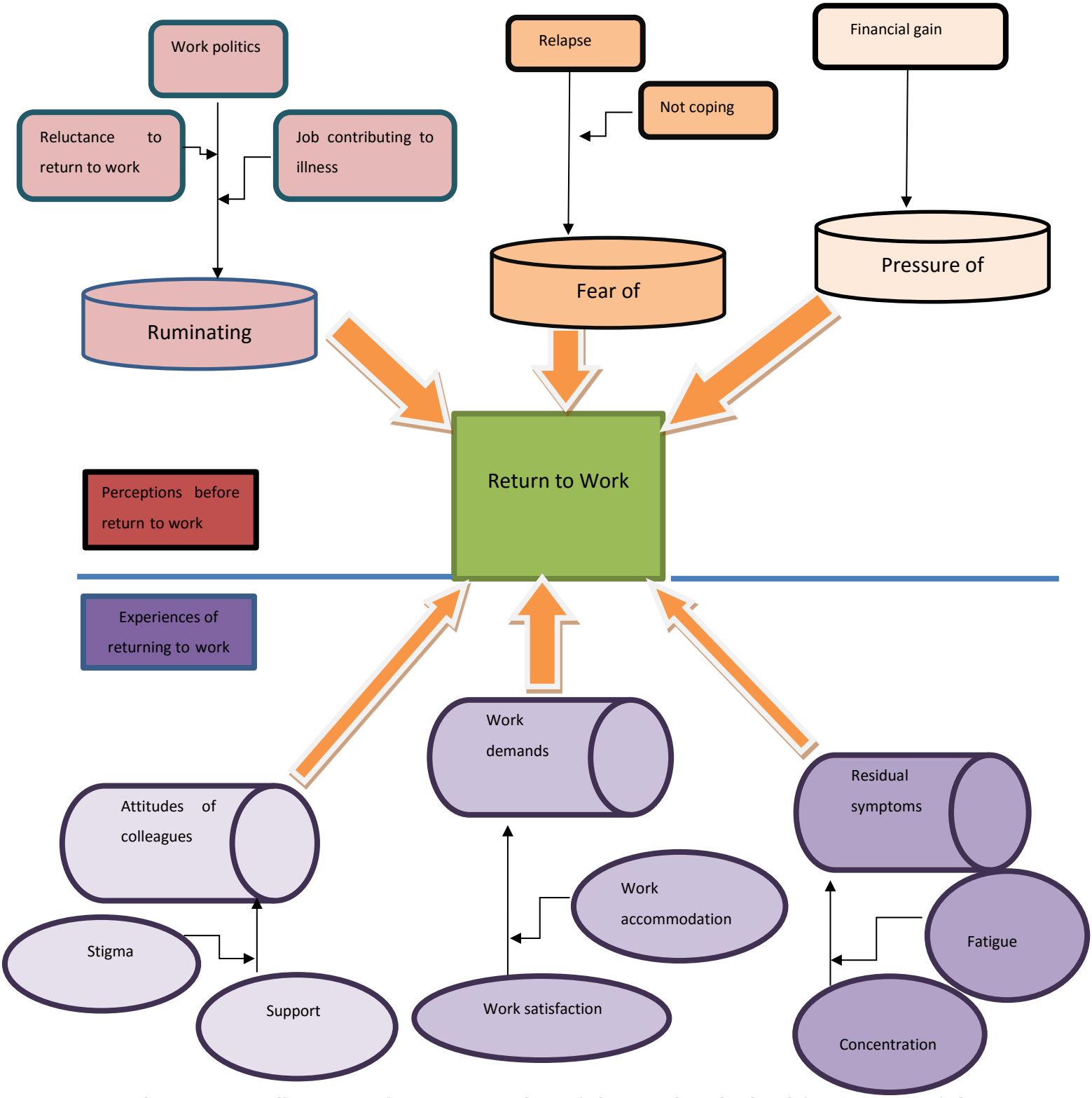

Figure 4.1: A diagrammatic representation of the results obtained from Part 1 of the study

4.2 Fit of results to the conceptual framework for cancer survivors

The aim of Part 2 was to identify the fit between the cancer survivor conceptual framework by Chow *et al*., (2014) and the results of the current study. The results of Part 2 were formulated in a Table 4.7, highlighting the fit between the results from a study by Chow *et al*., (2014) and that of the current results. The Table 4.7 highlighted what was similar between the two studies. The similarities were observed in the financial factor component, parts of the health factor component and in the environmental factor component.

Table 4.7: The fit between the existing conceptual framework and the current study

COMPONENTS OF CANCER SURVIVORS' STUDY	COMPONENTS OF THE MAJOR DEPRESSIVE DIOSRDER CLIENTS (CURRENT STUDY)
Return to work: Return to work was the ultimate goal for cancer survivors. They demonstrated hope to RTW which may be linked to their desire for better health and concerns around their mortality.	The participants did not experience the desire to RTW as they ruminated on their perceptions regarding work contributing to their diagnosis of MDD and chances of experiencing work politics, not coping and fear of relapsing upon RTW.
Financial Factor **Financial pressure:** Cancer survivors believed that it was difficult for them to get employment again due to age and therefore feared losing their jobs. **Health insurance:** The cancer survivors were motivated to RTW by the health insurance. This was because it is difficult to be insured after a cancer diagnosis.	**Financial pressure:** The financial pressures of the participants outweighed their reluctance to RTW. The participants had responsibilities of taking care of themselves and their families. **Health insurance:** The participants needed to continue working in order to pay their costly medical expenses because participants needed to continue receiving intervention from the MDT as well as take their medication.
Health Status **Disease related factors:** Cancer survivors with advanced stages of cancer had less chances of remaining employed. **Treatment related factors:** Cancer survivors who received chemotherapy had delayed RTW due to experiencing fatigue, continues hospital visits and lack of understanding from the colleagues. The long term cognitive effects of using chemotherapy also had a negative impact on RTW.	The effects of MDD on the participants were so severe that they needed to be hospitalised. However, they cannot be compared to that of cancer, despite that, they had affected the participants' ability to engage optimally in their everyday occupational performance areas including work. The participants experienced drowsiness which had a negative impact on their functioning. This contributed to them choosing to default on their medication.

COMPONENTS OF CANCER SURVIVORS' STUDY	COMPONENTS OF THE MAJOR DEPRESSIVE DIOSRDER CLIENTS (CURRENT STUDY)
Environmental Factors **Support from family:** The cancer survivors were motivated by their families to RTW for begin to engage in their occupational performance areas. **Support from the health professionals:** Support from the health professionals by a form of giving the cancer survivors an opportunity to choose when they wanted to RTW, attending evening therapy to decrease absenteeism and the communication between the health professionals and the employer. **Workplace environment:** The cancer survivors were motivated to RTW by receiving support through contact prior RTW and accommodation upon RTW.	The participants had reported having supportive family members which was important in their recovery and which ensured minimum pressure. Support from the health professionals did not come up. However, this support could have enabled communication with the employer which would have improved the insight of the employers regarding the participants' progress. Some of the participants that had RTW experienced the support from the workplace which enabled them to still continue with their job tasks. However, the other participants experienced what they perceived was stigma which perpetuated negative feelings towards work.
Personal Factors **Socio-demographics:** There was no association between early RTW and gender. Cancer survivors with higher educational level were likely to RTW.	The current study had more females than males and some of the participants were married. The participants in the current study were also in white collar jobs. It was clear that the participants' marital status did not have an impact on their perceptions towards RTW. This is because the majority of the participants were reluctant to RTW.
Work demands versus Work ability: The work demands needed to match with the survivors' ability to perform the work. Thus survivors in stressful jobs had more difficulties on RTW.	Due to residual symptoms and the high expectations from the employers, the participants struggled to perform their job tasks and thus were assisted by their colleagues to perform their job tasks. The participants that had RTW had to be fit to return to their normal job tasks.

4.3 The differences identified between the conceptual framework and the current study

The differences will be highlighted below in Table 4.8 which were observed in the personal factor component, parts of the health status factor component, the perceived experience of stigma and the absence of accommodation for others. The differences highlighted were mainly contributed by the context as the study by Chow et al., (2014) was conducted in a developed country and the current study in a developing country as well as the nature of the illnesses.

Table 4.8: The differences identified from the existing conceptual framework to the current study

COMPONENTS OF CANCER SURVIVORS' STUDY	COMPONENTS OF THE MAJOR DEPRESSIVE DIOSRDER CLIENTS (CURRENT STUDY)
Health Status **Co-morbid conditions:** The presence of other medical conditions had a negative impact on early RTW.	There was no evidence of co-morbid conditions as it was an exclusion criteria for the study. However, this factor cannot be ignored due to the nature of the illness and that it is related to other medical conditions such as cancer, HIV, etc. (Kinyanda, Hoskins, Nakku, Nawaz, Patel, 2011), (Carvalho, Hyphantis, Sales, Soeiro-de-Souza, Macedo, Cha, McIntyre, Pavlidis, 2014).
Cancer survivors with manual work tasks struggled upon RTW due to the effects of the illness and the treatment on the body. However, vocational rehabilitation in a form of constant contact during sick leave, accommodation and adjustment of work tasks was helpful for the cancer survivors to RTW.	The participants expected to be accommodated at work after their hospitalisation and absence from the workplace. However, most employers did not have knowledge on the progress of the participants and insight into the process of accommodation, some of the participants that had RTW did not experience accommodation.
There was no experience of stigma for cancer survivors instead, the colleagues were understanding of their illness and hospital visits and were subsequently supportive.	What was different with the participants with MDD was the experience of the perceived stigma on RTW. This is a consequence of the knowledge and belief systems of others about mental illness which had a negative impact on the participants.
The cancer survivors' self-esteem was not affected, instead, they started doing a lot of introspection about their lives and re-examined how they wanted to change their lives.	Some of the participants' self-esteem had been affected in that they did not believe in their ability or capacity hence they perceived fear of the chances of relapsing and the fear of not coping on RTW.

4.4. Conclusion

This section of the results analysed the fit between the existing conceptual framework for cancer survivors and the results of the clients with MDD from the current study. Table 4.7 and Table 4.8 give a list of the similarities and differences respectively. The analysis of the existing conceptual framework has assisted in modifying it for the

clients with MDD which will be discussed in the following chapter. Therefore, the following chapter discussed the results from chapter 4.

CHAPTER FIVE - DISCUSSION

5.1 Introduction

The purpose of this study was to explore the perceptions and experiences of clients hospitalised at Tshepo-Themba private hospital for the treatment of MDD of RTW. This was done to ensure that the work preparation programme offered within the occupational therapy practice at this hospital, considered and addressed the specific RTW needs and concerns of clients referred to this programme and addressed the factors which hindered seamless and successful RTW. This chapter will first discuss the sample and then the findings of the current study in terms of the three objectives established to guide the study, analysing and contrasting the findings to the existing literature.

5.2 Representivity of the sample

The validity and the reliability of any research findings is dependent on an appropriate sample. The study participants were purposefully selected as they were waiting to RTW or had already RTW after a period of hospitalisation and sick leave and thus were in a position to provide information about the research question (Creswell, 2013). In this study, the sample was small (n=8), as is typical of qualitative research (Creswell, 2013). Small samples are reported to limit the generalizability of findings of research. While this may be true, it may be argued that the sample studied in this research is a cohort of the South African population that has not been studied specifically with respect to RTW following a period of hospitalisation with MDD. Thus, although the study sample was small the participants represent an ever expanding group who may need mental health care services in the future.

5.2.1 Demographic profile of the participants

The demographic profile of the sample in this study was distinctive in that: all the participants were of African racial group, all grew up in poor socio-economic environments during the time of the oppressive political apartheid system in South Africa. In the post-apartheid period, they all found white collar level jobs in the mainstream economy and were earning salaries which had improved their socio-economic status, sufficiently classified as middle class. The middle class is broadly defined in two ways in South Africa: households with a monthly income of between R5600 and R40000 (Staff Writer, 2016) or individuals with an income of R10000-R25000 (Ndletyana, 2014). The middle class is mainly made up of nurses, clerks, teachers, and office workers, which were jobs held by participants in this current study (Ndletyana, 2014). As a condition of their employment status, all had access to a medical aid which allowed them to be admitted to a private psychiatric hospital for mental health care treatment.

So while this research studied only focused on the participants that were admitted to the Tshepo-Themba private hospital that specifically serves the population in Soweto, the majority of the clients seen are characteristic of the African clients now able to use private psychiatric care in South Africa. As this African racial group represents the majority group at 80.2% as indicated in the house hold survey that was conducted by Statistic South Africa (2014). In South Africa, the middle class is estimated to represent only 17% of the population and of that number, 51% are Africans (Ndletyana, 2014). This then highlights the importance of conducting research on this cohort. As no research has been published focusing on their perceptions and experiences of RTW following an admission for mental health care treatment, the results of this research will fill a gap in the knowledge of vocational rehabilitation intervention for this specific cohort.

Within this specific population, there is anecdotal evidence that there are unspoken and covert social pressures that they confront within the employment context. In the post-apartheid South Africa, individuals from previously disadvantaged groups with a

matriculation and post school training have greater employment opportunities enabling them to attain middle class status and move up the social ladder. At the same time there is a high unemployment rate (currently 26.7%) with many people under the age of 34 being unemployment (Stats SA, 2017). This raises spoken and unspoken fears about job security and consequences of losing this middle class status and all the opportunities it offers (Centre for Development and Enterprise Executive Summary, 2013). Complex economic factors have made it difficult for companies to retain their employees thus from time to time retrenchments are common. Understandably, there are considerable social and socio-economic pressures attached to all work positions as employees always have to prove that they are able to consistently perform their work tasks as required. Thus the macro-environment indirectly puts additional pressure on the 'new Black middle class' resulting in increased work pressure which may subsequently contribute to the MDD diagnosis, as reported by nearly all the participants. This is exacerbated by many people trying to find jobs, (although the number has slightly declined recently) resulting in high competition for a limited number of jobs resulting into more work pressure. There is a perception that those with a history of mental illness, including MDD, are often amongst those who are most likely to be retrenched and least likely to be considered for jobs and promotions (WHO, 2003).

All the participants as a condition of their employment were members of medical aid. In 2013, it was reported that only 18.4% of the population were members of medical aids (Stats SA, 2013). This afforded them to access private health care which included several specialists' to provide services including psychiatrists, occupational therapists, psychologists and social workers. This was very different to that of the public care system they had experienced when growing up. Having a medical aid for this cohort meant that health care resources are readily available and some of the expensive medical costs such as hospitalisation and costly medication for chronic conditions are covered. However, managed health care practiced by most medical aids, only allows for a maximum of 21 days admission with limited funds to cover outpatient follow-up appointments. This has in many cases proved to be insufficient

due to the complexity of MDD as even after the extended sick leave, the majority of the participants still had residual symptoms. A study by Garcia and Villa (2009) which reported that about 30%-40% of clients diagnosed with depression experienced residual symptoms for a considerable time after intervention.

5.2.1.1 Gender of the participants

While the sample of participants was unique with respect to their socio-political background, they were consistent with other studies in terms of their other demographic characteristics. In the current study there were more female participants (n=6) compared to male participants (n=2). This gender bias in MDD has been reported in other local studies and globally (Richards & Sanabria, 2014) (Strine, Mokdad, Balluz, Gonzalez, Crider, Berry & Kroenke, 2015). There are no clear reasons for this gender bias; however, this bias has been reported to be linked with the biological differences between males and females, (Albert, 2015). Additionally it has also been reported that males take a longer time to seek help when experiencing symptoms of MDD and prefer not to be hospitalised and hence this also may contribute to the reason for seeing more females than males in hospital settings. A study on consulting patterns found men consulted 32% less than women and men are less likely to attend follow-up appointments than women (Wang, Hunt, Nazareth, Freemantle & Petersen, 2013). While RTW studies have reported that women diagnosed with MDD take longer to return to work than males (Johansson, Lundberg & Lundberg, 2006). In the current study all participants were still attending follow-up appointments with the MDT. Although all the participants from the current study attended their follow up sessions with the MDT, three participants (n=3) [37.8%] reported in the research interview that they had stopped taking their medication. This was in contradiction with the data from self-report questionnaires that they completed just prior to the interview, where only one participant (n=1) reported no longer taking the prescribed medication. A study focusing on compliance with medication reported that clients with MDD are amongst the less compliant at 26.9% (Ghaffari-Nejad,

Mashayekhi, Mazhari & Ghayoumi, 2015). The reasons reported for this high non-compliance were side effects (22.7%), forgetfulness (36.7%) and lack of interest (28%) (Ghaffari-Nejad *et al*. 2015).

5.2.1.2 Age range of participants

The ages of the participants in this study ranged from 25 years to 46 years. This age range of clients is consistent with a study done by Patten *et al*. (2006) as well as Castaneda, Olson, Cargill (2013), that report that symptoms of MDD typically appear from the age of 18 years to 29 years (Subramaniam, Abdin, Sambasivam, Vaingankar, Picco, Pang, Seow, Chua, Magadi, Mahendran & Chong, 2016). These ages are significan in the context of this study as they represent the begining of ones career development, however due to its cyclic nature, MDD also affects career development long term as well as job retention.

In this current study both the male participants and one female participant were married whilst one female was divorced. The rest of the female participants were single (n=5). The two participants (n=2) in this study who had not RTW at the time of data collection were both single women with no children. This differed from the findings of Vemer *et al.* 2013 and Bromberger *et al.* 2015, who found that married women took longer to RTW. The fact that the two single women (n=2) in this study had not RTW is attributed to the fact that these single participants had other family members in the households that were working and could assist financially even when the incapacity leave was taking longer. Whereas the other participants reported being under greater pressure to generate an income to take care of their responsibilities.

5.2.1.3 Education levels of participants

The participants in the current study had varied levels of education which as can be seen from the results ranged from secondary education (high school) to a tertiary education and training (university). It is probable that the level of education had assisted participants in propelling them up the employment ladder (Schleicher, 2013), however, such jobs are usually accompanied by high work stress. The current study suggests that stress at work was experienced by all participants regardless of their level of education, consistent with the study by Tomilson *et al*., (2009) and Pelissier *et al*., (2013). However, research by Aleksic *et al*. (2013) reported employees in higher positions experienced more stress at work due to the high demands of their jobs. The current study did not examine work stress per se only the stressors reported by participants with regards RTW after a period of hospitalisation for MDD. However many reported that work stress had contributed to their illness, which represented a perceived threat on their RTW.

5.3 Perceptions and Experiences of return to work (discussion of findings of Part 1)

This research found that during this period of sick leave prior to RTW, all participants reported perception and experiences about their RTW which created a lot of anxiety, feelings of self-doubt and insecurities. The unique characteristics of this sample of participants and the socio-political and socio-economic context of work as well as the social pressures that exist in the community contributed to these lived experiences.

As described above the participants in this study were all employees negotiating their way back into the open labour market following a period of illness in the new democratic South Africa. Each participant described the importance of their worker role although they each had a unique work experience in unique job contexts. However, a common view was that the job they held and the work demands had in some way contributed to their mental illness and the diagnosis of MDD but in spite of

this they had to return to their existing jobs as they had financial responsibilities and were under pressure to maintain their life style.

At the time of the in-depth interviews all participants had been hospitalised for a period up until 21 days as allowed by the medical aids but on discharge were not considered to be fit to return to work by the psychiatrist in charge who suggested an additional period of sick leave of lengths which varied from two months to four months. This is common in the South African private health context, as the privilege of accessing private health care for hospitalization care is never adequate to allow for in-patient care until recovery is complete.

5.3.1 The Lived Perceptions and Experiences of participants before they returned to work

In the period prior to RTW all the participants (theme 1), reported they experienced rumination regarding their stressors that may have contributed to their illness and their subsequent admission as persistent and preoccupying. The experience of constant negative thinking was consistent with rumination as described by Nolen-Hoeksema, Wisco, Lyubomirsky (2008) as constant, ongoing and fixated negative thoughts which may occur before or after being diagnosed. While rumination has been described as a common symptom associated with MDD, its' persistence in the recovery period has been reported to slow progress and prolong the depressed mood (Nolen-Hoeksema & Morrow, 1993).

This process of rumination was reported to be centred on the unresolved work stressors leading to hospitalization. This lived experience was consistent with studies by Waghorn & Chant (2005), Kassam & Patten (2006), and Simpson *et al.* (2015) that reported that the experience of work stress could lead to admission. The experience of ongoing rumination was also a result of the participants leaving the issues too late

and not consulting a health care worker earlier to assist with stress management also reported in a study by Simpson *et al*. (2015).

As common experiences amongst all the participants was ruminating about the perceived work politics despite the different work environments. Although other studies have not specifically researched rumination of work politics, a study by Lee, Joo and Choi (2013) indicated a positive association between depression and work related stress. This was consistent with studies by Wiegner, Hange, Bjorkelund and Ahlborg (2015), Khamisa, Oldenburg, Peltzer and Ilic (2015), which described that the experience of burnout and stress leading to symptoms of depression in the workplace. The implication of the constant negative thinking had an impact on their lack of motivation to RTW, as reported as a lived experience noticed in the participants of the current study. The other focus of the rumination experienced by the participants, was the negative perceptions about their inability to cope with work which they perceived as self-doubt and vulnerability in their job security.

5.3.1.1 Decision to return to work

By whom and how the decision to RTW was made was highlighted by participants. Health settings in different countries, particularly in developing countries, all have their own processes of diagnoses, intervention and further follow up session with regards to people with mental illness (Ekberg, Wahlin, Persson, Bernfot, Oberg, 2015). In the current study, neither the multidisciplinary team nor the participants were involved in the decision to RTW. This decision was made by the psychiatrist managing the case based on their medical clinical reasoning. The medical model approach to mental health care, is used at Tshepo-Themba Private Hospital whereby even though the psychiatrist refer to the different disciplines such as the social worker, occupational therapists and the psychologists, the psychiatrist still makes the final decision about the client's intervention and outcome thereof. Thus this way of treating a client does not involve the client (despite the client being stable) or the MDT. However, the client centred model which is more central to an occupational

therapy philosophy proposes that, the client is a key role player in the recovery process and thus need to be involved in decision making on their health and in case of RTW. The medical model approach apparent in this study differed from those studies done in developed countries. Where the MDT consisting of health care professionals with expert knowledge in areas such as psycho-education, functional assessment, psychopathology, etc, including the client contribute to important client centred decisions (Liberman *et al.,* 2001). The team may include professionals such as occupational therapists, psychologist, social workers, case managers and the employer amongst others to consider barriers and facilitators that may have an impact on RTW, (Liberman *et al*. 2001) and to improve RTW chances when intervention is done during the first six weeks of symptom being evident (Hoefsmit, Houkes & Nijhuis, 2012).

5.3.1.2 Fear about return to work

The participants in the current study reported experiencing a lot of fear related to their condition and its impact on their life which was also indicated in previous studies (Birchwood, Smith, Macmillan, Hogg, Prasad, Harvey, Bering, 1989, Keough & Fisher, 2001 and Kennedy *et al.,* 2007). The experience of fear the participants reported, was influenced by their perception of their illness and their experience of how their illness affected their daily functioning. All participants they experienced it as distressing. This finding was consistent with a study by Wernicke, Pearlman, Thorndike and Haaga (2006), where the participants all reported the experience of their illness is distressing. However, this can also be associated with 'personal stigma' as the participants reported that, they perceived their illness as a sign of weakness and failure. This finding is consistent with a study by Coppens, van Audenhove, Scheerder, Arensman, Coffey, Costa, Koburger, Gottlebe, Gusmao, O'Connor, Postuvan, Sarchiapone, Sisask, Szekely and van der Feltz-Cornelis, Hegerl (2013). When exploring the lived experience of fear, the participants mostly feared of relapsing. The fear of relapsing was particularly associated with the

participants who experienced their index episode. Whilst still waiting to RTW, the participants also experienced fear of not coping with their work tasks upon returning to work. Again, the employers and mangers have little awareness of the implication of this condition on workers and their work output. Most importantly there are no laws (only guidelines) protecting clients with depression as most people do not view MDD as a disability which is defined in the Employment Equity Act no. 55 of 1998 under item 5.1 as either a long standing or a recurring mental or physical impairment that hinders employability (The South African Department of Labour, 1998). These lived experiences and perceptions were consistent with a study by Mokoka, Rataemane, dos Santos (2012) that MDD is not considered a disability, as the client is expected to return to their premorbid functioning and that they can be involved in gainful employment.

5.3.1.3 Pressure to return to work

It was interesting that, despite both the challenges at work and the fear the participants experienced, most of the participants wanted to RTW due to meeting financial needs and responsibilities. The South African leave incapacity policy, only allows an employee (depending on company policy) to receive 75% of their monthly salary when the sick leave cycle (36 days in a three year cycle) has been exhausted. This subsequently affects the ability to pay off household costs and other debts, thus motivating the participants to RTW. Surprisingly, the financial pressure to RTW has been observed in participants with different types of mental illnesses including severe mental illnesses, as seen from a study that was done by Serowik, Rowe, Black, Ablondi, Fiszdon, Wilber, Rosen (2014), Ekberg *et al.* (2015) and earlier by Kennedy *et al*. (2007), Boyce, Secker, Johnson, Floyd, Grove, Schneider, Slade (2008) as well as a cancer study by Islam, Dahlui, Majid, Nahar, Taib and Su (2014). The participants that particularly experienced the financial pressure to RTW were the main bread winners and supporting their families was important and a major concern. This was consistent in a study by Islam *et al*. (2014).

5.3.2 The Lived Experiences and the perceptions of RTW of participants with MDD who have returned to work.

5.3.2.1 Attitudes of colleagues on return to work

It is important to note that the differences in perceptions and experiences of participants that had RTW and those that had not were observed. The five participants (n=5) that had returned to work, had different perceptions and experiences. The participants who had returned to work, experienced both negative and positive attitudes from their colleagues. The positive attitude from colleagues were perceived by the clients as receiving support and being treated in the same way as prior to admission which they perceived also motivated them to be at work. This was evidenced in a study by Vemer *et al*. (2013) that showed that positive attitudes from colleagues facilitate the RTW process and the RTW time. It was however, not reported in this study that the positive attitude of the colleagues shortens the RTW time. This is because the support that was experienced was received upon RTW and not prior. However, some clients experienced negative attitudes from their colleagues. This contributed to the changes in self-esteem experienced by the participants (Lagerveld *et al*., 2010). This was partly related to their colleagues' perceptions of the illness and the participants' underlying perceptions they already had that mental illness was a sign of weakness and something to be ashamed of. However, the colleagues too may not know how to deal with clients upon returning to work (Evans-Lacko & Knapp, 2014), which could have been perceived by the participants as a negative attitude.

5.3.2.2 Experience of stigma of Mental illness on return to work

Stigma is very commonly experienced by people with mental illness. Unfortunately this has been observed as an international and a local according to Hugo *et al.* (2003) and Seeman *et al*. (2016). The participants described experiencing perceived stigma upon their RTW, consistent with a study by Boyce *et al.* (2008). Boyce *et al*. (2008)

reported this to be a serious concern although in the current study, the experience of perceived stigma was not directly associated with RTW. The negative perception of self as expressed by the experiences of fear may also be contributed by internal stigma (Egbe *et al.,* 2014) which was seen to affect RTW (as reported by the participants that had not returned to work). However, internal stigma is a concept that has not been rigorously explored, it is not understood by many but it exists and was described by the participants.

5.3.2.3 Personal and work support on return to work

There were diverse experiences of support from managers and colleagues upon RTW. Adequate support from managers and colleagues before and after RTW has been associated with early RTW (Vemer *et al.,* 2013). The participants that had returned to work reported this to be helpful in transitioning back in to the workplace and coping with the demands of work. This was also consistent in the findings by Nieuwenhuijsen *et al.,* (2004). This also indicated acceptance and elevated the perception of worry about job security, a critical concern in the current South African work environment. Research suggests that, when managers are supportive, then the rest of the team (colleagues) also become supportive towards the individual diagnosed with MDD, which was also described by participants in the study by Nieuwenhuijsen *et al.* (2004).

The participants that did not receive support from their managers and colleagues, experienced immediate exposure to the stress they experienced prior to their hospitalization. They also described the importance of communication with the managers upon RTW which would have eased their transition back in the workplace. Communication with managers upon RTW was found to be important in ensuring a smooth transition back to work after a prolonged absence from work (Bender & Farvoldem, 2008). However, the association between manager and colleague support and RTW was not as evident in the current study, as it has been described in

the other studies (D'Amato & Zijlstra, 2010), (Sallis & Birkin, 2014). It appeared that support from the managers was important for the participants to ease transition back to work after sick leave from the participants' responses in the current study. These findings were similar to studies done by Flach *et al*. (2011), Pelissier *et al*. (2014), Evans-Lacko & Knapp (2014) and de Vries *et al.* (2014), Ekbladh and Sandqvist (2015).

5.3.2.4 Need for work accommodation on return to work

The provision of work accommodation upon returning to work after an illness is more common in developed countries with the assistance of a case manager. When both the employees and the employers (managers) do not have an understanding of the process of incapacity and principles of accommodation to facilitate health in the workplace, communication is often limited, and a RTW meeting upon returning to work may not occur. Some participants reported the experience of ongoing work stress due to immediate resumption of long working hours after a period of inactivity, increased work load and work demands still occurred even after returning to work as others had not been allocated their work tasks (Sallis & Birkin, 2014). Graded RTW can be a work based accommodation programme that could either consist of reduced work hours, decreased workload, more supervision and support, amongst others, dependent on the companies' financial strengths (Hogelund, Holm & McIntosh, 2009).

The Code of Good Practice: Dismissal (CGP: D) within the Labour Relations Act 66 of 1995 (The South African Department of Labour, 1995) gives guidelines to address both temporary and permanent incapacity leave due to ill-health or injury. The CGP: D does so using different approaches. These approaches are subsequently used by the managers to address accommodation when needed. Managers usually address incapacity with the assistance of the occupational health medical practitioner that is employed or contracted by the company. However smaller companies may not be able to afford to hire these professionals. This process also includes human resource

personnel to communicate and give personal and financial advice to the employee and the employer about any disciplinary issues (Strasheim, 1996). The CGP:D gives the following three steps as a general guideline to the process of temporary incapacity thereby leading to reasonable accommodation for the employee, during reasonable and unreasonable temporary absence; to assess the number of days that the employee has been off from work (whether it is within the 36 days of the three year cycle or has exceeded this), (Strasheim, 1996); to Investigate all the possible alternatives by conducting a transparent investigation to explore alternative job tasks for the employee affected and for an occupational therapist to conduct an assessment evaluating the capabilities of the employee to perform the old tasks or the new tasks; and to evaluate types of possible alternatives as the new job tasks will depend on the length of the illness and the financial impact on the company (Strasheim, 1996).

The above process appears to have not been implemented in the participants' different work environments as some of the participants only reported being given less job tasks that were slowly graded up over two weeks. However, this process has not been directly linked to RTW despite evidence that this process facilitates early RTW (Bethge, 2016).

5.3.2.5 Lack of work satisfaction on return to work

The experience of poor work satisfaction was described by the majority of the participants that had returned to work. Amongst others, this was reported to have been contributed to the ongoing stressors at work that were experienced prior to the participants' admission. These findings were consistent with previous studies (Okechukwu *et al*., 2012), (Corbiere *et al*., 2015). Factors perceived to contribute to low job satisfaction included work overload, time pressure, the type of work and long working hours, poor growth and development opportunities amongst others. These were similarly identified in earlier studies by Moen, Kelly & Lam (2013) and Chow *et al*. (2014). This subsequently highlights the importance of fair work distribution

amongst all employees so that each has equal and manageable workload; and support to employees who have high responsibilities as they will not be experiencing as many challenges subsequently enjoying their jobs (Pelissier *et al*., 2014).

5.3.2.6 Residual symptoms on return to work

The ongoing experience of residual symptoms even after the participants had returned to work such as fatigue and poor concentration was reported to be experienced by most of the participants (Schene *et al.,* 2007), (Sato & Yeh, 2013). A study by Stewart *et al*., (2003) reported that 2.4% of 9.4% of people diagnosed with MDD in their study reported having residual symptoms. Fatigue was largely under-estimated as the participants perceived that it was associated with the period of unproductivity from the extended sick leave. The residual symptoms appeared to affect the ability of the participants to function at work and perform their daily work tasks was also described. These findings were similar to other studies (Ross, 2007), (Simpson *et al*., 2015). It was reported by Bender and Farvoldem (2008) that residual symptoms are often misunderstood as medication effects and hence it was found in the current study that some of the participants stopped taking their medication as a result. These residual symptoms decreased work productivity which was also reported by Mintz, Mintz, Arruda and Hwang (1992), subsequently resulting into presenteeism which is often not noticed or appreciated by many including the managers/supervisors. It is also reported that clients with ongoing residual symptoms are at a higher risk of relapsing (Paykel, 2008). Below is the modified RTW conceptual framework for clients with MDD which will be discussed in Part 2.

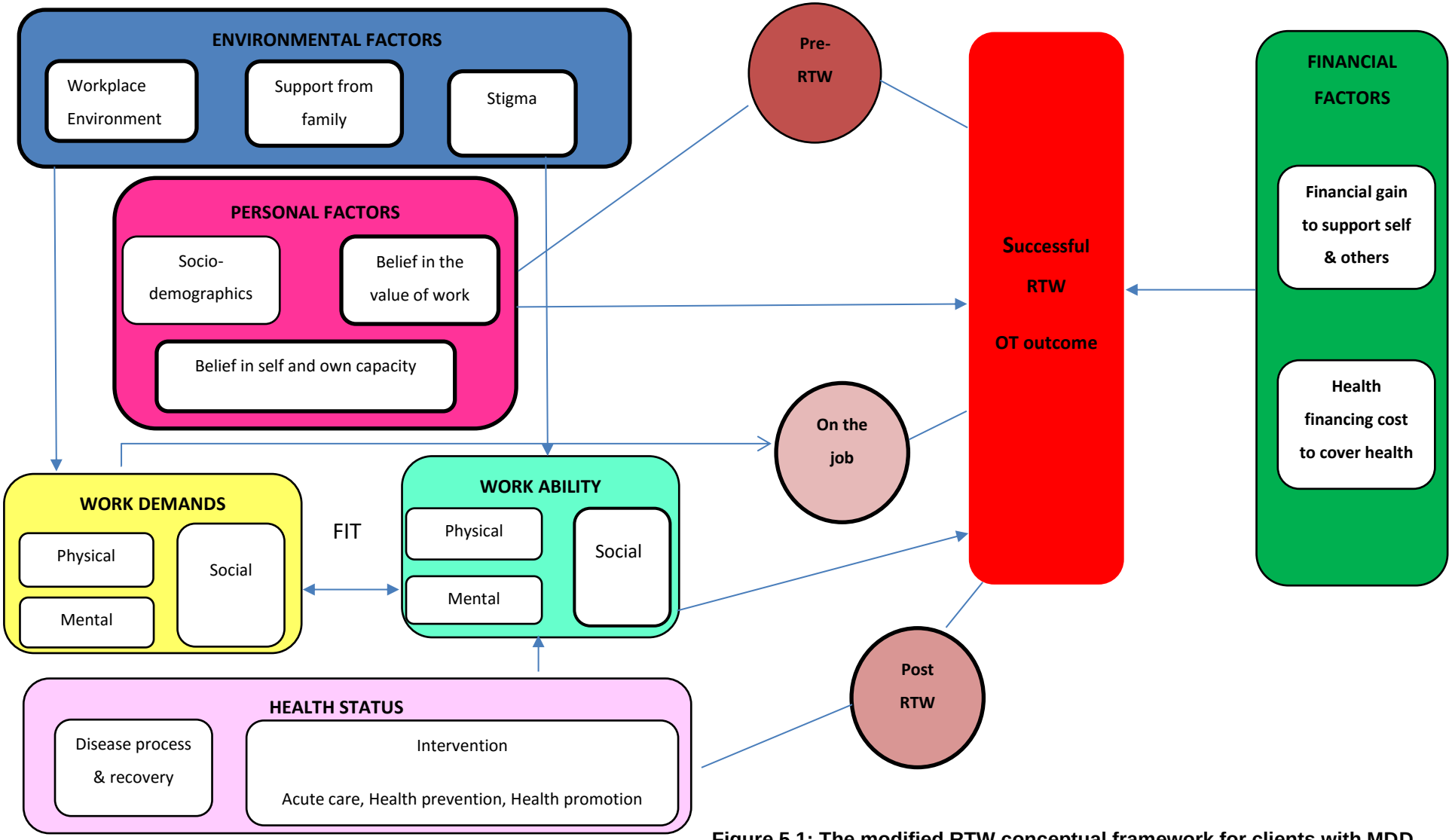

Figure 5.1: The modified RTW conceptual framework for clients with MDD

5.4 Relating findings of the results to the return to work conceptual framework for cancer survivors (discussion of Part 2)

In Part 2 of the study, the results of Part 1 were analysed in terms of the conceptual framework for cancer survivors by Chow *et al*. (2014). While there were similarities, there were a number of differences which appeared important from the participants' perceptions and experiences that needed inclusion in the vocational rehabilitation process of MDD.

5.4.1 Successful return to work (occupational therapy outcome)

From a clinical perspective, the outcome of any occupational therapy intervention is a successful RTW. From an occupational therapy perspective, what these results suggest is that there are three phases namely pre-RTW, on the job and post RTW phase. All these phases need the occupational therapist as a case manager to be involved in order to facilitate RTW. Literature reports that occupational therapist can assume the role of case management especially due to their knowledge of how illness may have an impact on function (Ross, 2007). The pre-RTW phase addresses challenges that are perceived and experienced by clients. These challenges include all the factors identified in the first theme. These are perceived fears which were chances of relapse and not coping in the work place, rumination about the job contributing to the illness, work politics, reluctance to RTW and social pressures that come with being absent from the work place. The on-the-job phase addresses the fit between the work demands and the ability of the client to cope with these which may be influenced by many other factors. The last phase addresses the challenges that the client may experience after work accommodation has been implemented which includes stigma from the colleagues and continued support from the employer.

5.4.2 Financial Factors

5.4.2.1 Financial gain to support self and others

There is a lot of literature on RTW and its value (Ross, 2007) and (Lloyd, 2010). In this cohort, the main drivers were the need to RTW for financial reasons. This was also reported in a previous study by Kennedy *et al*., (2007) that finances influences early RTW. This in particular was a motivator for the participants with MDD as the unemployment rate in South Africa is high at 27.7% (Stats SA, 2017) and having a mental illness is directly linked to poverty (WHO, 2003) due to poor employability. Nonentheless, the loss of income due to unemployment after prolonged sick leave has a socio-economical and socio-political implications. For the client with MDD, this does not only affect them but the family at large. However, the loss of income also means a drop in the social status whereby the clients are unable to meet their needs. This may have a long lasting effect on the already sensitive self-esteem, prolonging the illness thereby perpetuating disability.

5.4.2.2 Health financing cover costs for adequate care

The medical expenses for the cohort was paid for by medical aid which is partially subsidised by the employer as part of employment benefits. Despite this, the financing was not adequate to cover for both in-patient and out-patient care, as the cohort was worried abut their medical aid funds being exhausted due to the number of follow-up appointments with different health professionals they need to attend. This was a huge concern by the cohort as inadequate medical aid funds means that they need to access public health care. However, the public health system which serves much of the population is over burdened (Burns, 2011), and there has been a lot of questions posed to the quality of psychiatric services offered in South Africa. Therefore, a loss of a job will entail that one needs to access the public health sector which is already burdened. Thus, employment gives an individual the opportunity to access and pay for private health care through membership with a medical aid which

enables access to specific allied health care visits that are essential for an early and a successful RTW process. Thus this highlights the importance of adequate funding for this complicated illness.

5.4.3 Environmental Factors

This study found a number of environmental factors that affected RTW. In this section, the findings of the study related to the workplace environment, supportive environments created by family and friends, and healthcare practitioners respectively, as well as the impact of stigma will be discussed with reference to the literature.

5.4.3.1 Workplace environment

It was clear from the current study that not only personal factors but the work environment can also influence RTW as reported by Jansson & Bjorklund (2007). Participants in this study indicated that the need for reasonable accommodations affected RTW. The need for provision of reasonable accommodation was also reported in other studies (Jansson & Bjorklund, 2007). However, poor awareness and understanding of mental illness in the South African work environment and poor insight of the South African Labour Law practise for employees on sick leave due to ill-health had an impact on early RTW as seen in the current study. Furthermore, reasonable accommodation as a process of support is limited by the client disclosing their illness and also the interpretation of the Employment Equity Act 55 of 1998 (The South African Department of Labour, 1998) as well as stigma and discrimination (Hugo *et al*., 2003) of people with mental illnesses including MDD in the South African context.

5.4.3.2 Supportive environment from family and friends

In the current study, support from family was not directly linked to RTW, but may be an important factor to consider during all the phases of treatment. This is because both the clients that had returned to work and those that had not, had received support from family and friends as seen in the questionnaires that they completed. This study's findings are different from other studies, where support from family and its impact on RTW for ill or injured people was reported (Chow *et al*., 2014), (Egbe *et al.,* 2014). This form of support is important when family is positive regarding the value of work because it encourages and motivates the clients when they are experiencing all the worries regarding RTW. The RTW conceptual framework for cancer survivors by Chow *et al*., (2014) and the conceptual analysis by De Vries *et al*., (2012) reported a direct link between the supportive environment that family and friends provide and the ability to work as well as the values of work.

5.4.3.3 Supportive environment from health care professionals

Support from the medical team did not come up in the current study. However, , literature reports that it is an important factor to consider, particularly during all the phases of the vocational rehabilitation process (De Vries et al., 2012) and (De Vries, Hees, Koeter, Lagerveld, Schene, 2014) to ensure adequate collaboration between the client, the employer and the medical team.

Participants in the current study indicated that they received mostly medical support, especially in the clients' acute phase of their illness as the clients needed to be medically stable. To the contrary, a study by De Vries *et al*., (2012) reported that the medical intervention was not a great influencer for RTW but rather the communication and guidance and support of health professionals towards the supervisors of the employees with MDD. This guidance can be given mostly by occupational therapists as they have vast knowledge and expertise regarding vocational rehabilitation (Esselman *et al*., 2007, Schene *et al*., 2007). This study was conducted at a private

hospital and all contacts by the medical team to the clients and for the clients needed to be funded by medical aid which negatively impacted on participants' ability to access other services, including communication and guidance from health professionals to the participants' supervisors. Therefore, for a successful RTW outcome for this cohort, guidance from the medical team is important, contrary to the literature.

5.4.3.4 Stigma

Participants indicated that stigma was an important factor in RTW. This factor is crucial in all the phases of RTW. The experience of stigma will influence the clients' belief in themselves as well as in the value of work. If this is left unchallenged, it will have an impact in the clients' ability to execute their work thereby perpetuating fears of not coping in the work place, therefore by addressing this factor, the clients will RTW therefore showing their work potential as reported by Lloyd (2010). Stigma can also be experienced in the community (Hugo *et al*., 2003), or within the family which may demotivate the clients to RTW thereby increasing the duration of their sick leave.

5.4.4 Personal Factors

This study had findings that were unexpected in relation to personal factors affecting RTW. This study's findings regarding personal factors of socio-demographics and belief in the value of work will be discussed in comparison to the literature.

5.4.4.1 Socio-demographics

In the current study, socio-demographic factors e.g. age was not linked to RTW, neither was educational level of the clients. This finding was similar to studies that were conducted by Nielsen, Madsen, Bultmann, Christensen, Diderichsen, Rugulies

(2010), Nielsen, Bultmann, Madsen, Martin, Christensen, Diderichsen, Rugulies (2012) and Muijzer, Brouwer, Geertzen, Groothoff (2012). The participants that had not returned to work in the current study were female and single. A study by Vemer *et al*. (2013) reported that women take longer to RTW than men. However, the current study had more female participants than males, thus there was no significant association between females taking longer to RTW than males. The single female participants in the current study experienced delayed RTW whilst the married females experienced early RTW. The single females experienced support from their families which motivated them during the time they were awaiting to RTW. This finding was different from a previous study by Bromberger *et al*. (2015) who reported that married women took longer to RTW than single women due to family support and them not being breadwinners. Therefore, the socio-demographic factors are to be addressed in all phases.

5.4.4.2 Belief in the value of work

This factor needs to be addressed in all phases, because the participants need to believe in the importance of work in their lives. The clients in the current study experienced poor job satisfaction and were reluctant to RTW due to the perceived worries regarding work politics. Despite these negative feelings towards work, the participants were still able to RTW. This finding was different to that of a study by Fayad *et al*., (2004) and De Vries *et al*., (2012) which reported that when people have poor job satisfaction, they take longer to RTW after an illness.

5.4.5 Health Status

The findings regarding the health status factors will be discussed and compared to the available literature.

5.4.5.1 Disease process and recovery

In the current study the clients believed that drowsiness, fatigue and poor cognitive function were as a result of medication. Research reports that most of the clients stop medication due to the belief that it causes the above (Bender & Farvoldem (2008). Therefore, the health status of the client needs to be considered during all phases. This is mainly because research has reported that MDD affects career development long term as well as job retention due to its cyclic nature with chances of being diagnosed with another episodes in their lifetime (Bonde, 2008), (Subramaniam *et al*., 2016). Therefore when the clients are informed of the importance of being adherent to their medication, being compliant on their different appointments with the MDT and exploring different kinds of coping skills, this can assist with the recovery process to manage the symptoms (Lloyd, 2010). It is important to also consider the experience of residual symptoms which will have an impact on executing job tasks which was reported by Adler *et al.* (2006).

5.5 Conclusion

The results have highlighted perceptions and experiences of clients with MDD on RTW. These factors can be addressed in the three different phases namely pre-RTW, on-the-job and post-RTW. However, the pre-RTW programme that was used in the researcher's clinical context was not sufficient as some clients experienced delayed RTW. This was contributed by the lack of insight by the medical team into the clients' perceptions and experiences whilst awaiting RTW. The modified RTW conceptual framework for clients with MDD will be useful for practitioners working in the similar clinical context. However, this process may be problematic as clients depend on the use medical aid and funding for all three phases may not be approved by the medical aid schemes. Therefore, it is important for the practitioners working with clients diagnosed with MDD to adapt their intervention programmes particularly the pre-RTW phase and the post-RTW as these are funded by medical aid schemes

(despite limited funding) in a form of in-patient intervention and follow-up appointments post discharge.

CHAPTER SIX - CONCLUSION

6.1 Introduction

This last chapter will give an overview of the main findings of this research highlighting the two themes that emerged from the study. This chapter will also describe the limitation of the study and identify further recommendations thereof. Finally the implications of the results for the occupational therapy profession particularly in vocational rehabilitation will be highlighted.

6.1.1 Overview of the study

It is clear that the prevalence of MDD in South Africa is increasing (Tomlinson *et al*., 2009) as more and more people are being diagnosed with the illness. The increase in the prevalence is particularly seen in the workplace with all the socio-political and socio-economical stressors in the South African work environment. When this illness is left unmanaged, it affects engaging in all the occupational performance areas. Despite this, clients with MDD have the capacity to RTW after hospitalisation and prolonged sick leave.

The aim of the study was to explore the lived perceptions and experiences and of clients with MDD on RTW. Therefore the focus was to study a unique cohort on the participation and engagement in the work area and all the factors that influence this. The researcher chose this topic particularly because WHO reported that by 2020, MDD will be the second highest global burden of disease (Andrews, Sanderson, Slade & Issakidis, 2000). It is known that MDD does not only affect the client, but the employer and therefore the economy at large as when more clients are on longer sick leave then they are unable to contribute adequately to their families and to the economy. What was interesting was that some clients experienced difficulties with RTW and some did not despite receiving the same intervention. The researcher

hoped to identify the clients' perceptions and experiences barriers and facilitators from their own perspective that will assist in informing a comprehensive vocational rehabilitation intervention to assist the clients with a smooth transition to work. The facilitators of RTW for this unique population were:

- Meeting their financial needs and responsibilities
- Positive attitude of the family and colleagues

The barriers to RTW for this unique population were:

- The experience of residual symptoms
- Negative attitudes of colleagues
- Fear of chances of relapsing and/not coping
- Rumination about work

Despite the challenges that these clients were facing, regarding RTW, work came with financial benefits for them to support their families. Identifying these barriers and facilitators will assist the occupational therapists working with clients with MDD in providing a comprehensive and an improved intervention that is informed by evidence from research. Case management was also observed to play a crucial role in ensuring a smooth RTW for clients with MDD. However, there are a few occupational therapists at 0.13 per 100 000 people (Burns, 2011) and the managed health care also limits funding for medical aid users, thus a strengths model developed by Selander and Marnetoft, (2005) may be used to address issues experienced at work. Below are the principles of the strengths model listed:

- Focusing on the client's strengths and not weaknesses
- Ensuring that the relationship between the client and the therapist is good
- Ensuring that the client centred approach is used whereby the client gives the direction of where they want to be
- Use the community resources and not to view it as a barrier

- Avoid office based intervention when possible and work with the client's strengths.

There were three objectives of the study and these were to explore the lived perceptions and experiences of the clients diagnosed with MDD that had returned to work and those that had not returned to work. The last objective was to modify or redesign a conceptual framework for clients suffering from MDD to guide the occupational therapy vocational rehabilitation intervention program for these clients following an episode of absence from the workplace.

Due to limited literature on MDD and RTW, it was challenging to find a RTW conceptual framework on MDD, however, a RTW conceptual framework for cancer survivors by Chow *et al*. (2014) was subsequently chosen due to the similarities identified and thus modified to meet objective three of the study, see Figure 5.1.

6.1.2 Themes that emerged

A descriptive qualitative method assisted the researcher to elicit the two themes that emerged from the participants, which were 'waiting to RTW' and 'perceptions and experience on RTW'.

The period of waiting to RTW after hospitalization was stressful due to perceived work issues and rumination about work politics that were perceived to contribute to the illness. Despite the constant rumination, the clients wanted to RTW which was contributed by the perceived social pressure mainly meeting financial needs and responsibilities as clients were breadwinners. Simultaneously, the clients also experienced perceived fears about RTW which included chances of relapsing and not coping on RTW.

The experience of RTW was made positive by supportive family, colleagues and managers. However, most colleagues may not know how to treat clients with MDD,

thus clients may experience perceived stigma which is also contributed by self-doubts and insecurities. The experience of side effects from the medication and the residual symptoms may affect the capabilities to perform their job tasks as expected thereby perpetuating presenteeism. The modification of the existing conceptual framework by Chow *et al*. 2014, has assisted in determining the three most important phases of a successful RTW process. These phases included the pre-RTW, on the job and post-RTW. The inclusion of the employer and the health professionals in the process of RTW, may encourage communication thus subsequently improving support in a form of reasonable accommodation where possible. The follow-up appointments post-RTW will also be useful to address any difficulties experienced such as difficulties performing job tasks due to residual symptoms.

6.1.3 Limitations

The study was conducted with clients diagnosed with MDD thus failing to address the other population of clients with other mental illnesses such as Schizophrenia, Bipolar Mood Disorder and Psychotic Disorder amongst others. The study was done with a selective targeted sample from a specific context therefore this may affect the generalizability of the study to other private clients seeking intervention needing to RTW.

The study was conducted at the same hospital that the clients were seen during their acute phase of their treatment. Therefore they may have used the semi-structured interviews as a form of therapy.

The second phase of member checking was not done. Thus the themes of the study were not sent back to the participants in order to verify the true reflection of the reported perceptions and experience as the researcher was working at another hospital and the contact details of the participants had changed.

6.1.4 Recommendations for the use of the results in practice

The results of the study indicate the importance of using a client centred model which is key in the occupational therapy process. This entails the need to involve the clients and consider their perceptions and experiences. Support from the family, the colleagues, managers and the MDT is also important as this will motivate the clients to RTW. The modified conceptual framework indicates that intervention needs to be initiated before RTW and continue until clients have RTW and are not experiencing any factors identified that will impede performing their job tasks. Reasonable accommodation is also important and can be facilitated by an occupational therapist as these clients are vulnerable and may present with insecurities due to their illness. This process will enable the clients to still be employed, engage in an occupational performance area that will assist in improving their self-esteem and continue to contribute to their families and the economy at large. Intervention will be facilitated through individual and/or group therapy. What is important is that the occupational therapists need to also advocate for clients with MDD to remain employable through the interaction with the employer during all the phases which will always keep the employer updated on the progress of the client (provided that the client gives consent on disclosing their illness).

6.1.5 Recommendations for future studies

It will be interesting if the same study would be done in another province within South Africa to compare and see whether the same results will emerge. The results of this study only highlighted the perceptions and experiences of clients, but it would be of interest to identify the perceptions and experience of employers regarding clients diagnosed with mental illness on their RTW process. Future research may also be conducted to test the conceptual framework in practice and evaluate whether addressing those factors explored do improve early RTW. The process of RTW can be lengthy and costly and therefore it will be beneficial to look at alternative funding

for this process in light of the National Health Insurance (NHI). It is important to also look at cost analysis in the long term to evaluate if this process will reduce the chances of relapse, early RTW, presenteeism and absenteeism upon RTW, financial stressor (due to prolonged sick leave) and the economy at large. It will be also be important to receive feedback from the Gauteng Vocational Rehabilitation Task Team for comment regarding the factors in the modified conceptual framework. There is also an urgent need to look at clients with no previous work history but have psychiatric conditions and evaluate if this process will enable the participants to be employable.

6.2 Conclusion

This chapter was able to summarise the whole study by giving a brief overview of the study and the themes that emerged from the study. The researcher was able to evaluate the study by indicating the limitations. Recommendations for the use of the results in practice were indicated. Finally recommendations for further research were made.

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APPENDIX A

PERSONAL INFORMATION	VOCATIONAL PROFILE
Participant no:	Highest grade passed at school:
Gender:	Tertiary qualification:
Age:	Age you started working:
Marital status:	Recent courses attended:
How many children do you have:	Previous positions held:
Who do you live with at home:	Reason for leaving the jobs:
Do you have supportive friends:	Current place of work:
HEALTH INFORMATION	Type of institute (government, municipal, private):
What chronic illness do you suffer from:	Position held:
Date of diagnosis of Major Depressive Disorder:	Do you supervise anyone:
Are you still taking your medication:	Distance of place to work from home:
Estimated duration in hospital:	Time taken to travel to work:
Duration of sick leave (including admission time):	Type of transport used:
	Working hours per week (including breaks):
	Reason for working:

APPENDIX B

Clients that have returned to work

1. Tell me more about your job or what you do at work
2. Do you think that your job may have contributed to your illness?
3. How do you feel about being diagnosed with MDD?
4. Tell me about your first day when you went to work after discharge
5. What motivated you to return to work after your sick leave?
6. What were your challenges or fears when you returned to work?
7. What discouraged you when you had to go back to work?
8. How were your colleague's behaviour? How was your supervisors' behaviour towards you?
9. How did you find the physical work environment?
10. How did you experience your job tasks?
11. What helped you to perform your job tasks as expected?
12. What were your main expectations?

Clients that have not returned to work

1. Tell me more about your job or what you do at work
2. Do you think that your job may have contributed to your illness?
3. How do you feel about being diagnosed with MDD?
4. How does it feel being on a long sick leave?
5. What kind of support are you receiving from work?
6. How does your family treat you now that you are at home?
7. How has your income being affected?
8. How has your confidence and self-esteem been affected by the long sick leave?

APPENDIX C

1. How was your first day at work?
2. What motivated you to return to work after your sick leave?
3. What were your challenges or fears when you returned to work?
4. What discouraged you on your return to work?
5. How were your colleagues/supervisor/manager's behaviour on your return to work?
6. How did you find the work environment on your return to work?
7. How did you experience your job tasks?
8. What helped you perform your job tasks as expected?
9. What were your main expectations upon your return to work?
10. What other additional information about your experience when you returned to work do you have?

APPENDIX D

PARTICIPANT INFORMATION SHEET

Hello,

I am Lebohang Saohatse qualified as an occupational therapist. I am a Masters student at the University of Witwatersrand. The title of my study is “Experience and perceptions of return to work by clients with Major Depressive Disorder”. The aim of the study is to explore the factors that influence return to work for employees with Major Depressive Disorder.

I am inviting you to take part in a research study. Before you accept, it is important for you to understand the purpose of the research as well as what it will involve. Please take time to read the following information carefully and discuss it with others if you wish. Please ask if there is anything that is not clear or if you would like more information. Take time to decide whether or not you wish to take part.

I am asking you to take part in the study as you have valuable knowledge and experience about you return to work after being diagnosed with Major Depressive Disorder.

You will be asked to come in for an hour interview by the researcher. I am asking your permission to record the interview and the purpose is for the researcher to use it when transcribing data.

The data will be transcribed using a specialised software in order to identify the different themes that will come out of the interview. After this, the tapes will be stored in a secure locked place for six years as according to HPCSA regulations and then they will be destroyed.

No names of participants will be included in the research only their perceptions and experiences. It is up to you to decide whether or not to take part. If you do decide to take part, you will be given this information sheet to keep and be asked to sign a

consent form. If you decide to take part you are still free to withdraw at any time (provided that you inform the researcher) without giving a reason and without detriment to yourself. If there are still existing symptoms of depression, I will give you names of the psychologist around your area that may provide psychological support.

Feedback will be available on request. And I may contact you to clarify the information once the results have been analysed.

If you have any questions or concerns about this study or if any problems arise, please contact Lebohang Saohatse at 073 7950645 or lebosaohatse@gmail.com. Should there be any ethical queries about the research please feel free to contact the Human Research Ethics Committee (HREC) Chairman Prof P Cleaton-Jones at +2711 7171234 or anisa.keshav@wits.ac.za for reporting of complaints / problems

Lebohang Saohatse

APPENDIX E

CONSENT FORM FOR PARTICIPATION IN A RESEARCH STUDY

Informed Consent

I have read this consent form and have been given the opportunity to ask questions.

I therefore give my consent to participate in this study. "Experience and perceptions of return to work by clients with clients with Major Depressive".

Participant's signature: _____ Date: _____

APPENDIX E

CONSENT FORM FOR BEING RECORDED (AUDIO) WHEN PARTICIPATING IN A RESEARCH STUDY

Consent to be Audio recorded

I have read this consent form and have been given the opportunity to ask questions.

I therefore give my consent to participate in this study.

Participant's signature: _____ Date: _____

APPENDIX F

	P1	P2	P3	P4	P5	P6	P7	P8
Rumination	✓	✓	✓	✓	✓	✓	✓	✓
Reluctance to RTW	✓	✓	✓	✓	✓	✓	X	✓
Work Politics	✓	✓	✓	✓	✓	✓	X	✓
Job causing illness	✓	✓	✓	✓	✓	✓	X	✓
Fear	✓	✓	✓	✓	✓	✓	X	✓
Relapse	✓	✓	✓	✓	✓	✓	✓	✓
Not coping	✓	✓	✓	✓	✓	X	X	X
Press to RTW	✓	✓	✓	✓	✓	✓	X	X
Financial gain	✓	✓	✓	✓	✓	✓	X	✓
Attitudes of colleagues	✓	✓	✓	✓	✓	✓	✓	✓
Stigma	✓	✓	X	X	✓	✓	X	✓
Support	✓	X	✓	✓	✓	✓	X	X
Work demands	X	X	✓	X	✓	✓	X	X
Work accommodation	X	X	X	X	X	✓	X	✓
Work satisfaction	X	X	X	X	X	✓	X	X
Residual symptoms	✓	✓	✓	✓	✓	X	✓	✓
Waiting to return to work	✓	✓	✓	✓	✓	✓	✓	✓
Return to work experience	✓	✓	✓	✓	✓	✓	X	X

APPENDIX G



UNIVERSITY OF THE WITWATERSRAND JOHANNESBURG

Private Bag 3 Wits, 2050
Fax: 027117172119
Tel: 02711 7172078

Reference: Ms Thokozile Nhlapo
E-mail: thokozile.nhlapo@wits.ac.za

06 February 2015
Person No: 441704
PAG

Miss LE Sechatse
21423 Zone 14
Sebokeng
1983
South Africa

Dear Miss Sechatse

Master of Science in Occupational Therapy: Approval of Title

We have pleasure in advising that your proposal entitled *Experience and perceptions of clients with major depressive disorder around their return to work* has been approved. Please note that any amendments to this title have to be endorsed by the Faculty's higher degrees committee and formally approved.

Yours sincerely

Mrs Sandra Benn
Faculty Registrar
Faculty of Health Sciences

APPENDIX H

R14/49 Ms Lebohang Etheldreda Saohatse

HUMAN RESEARCH ETHICS COMMITTEE (MEDICAL)

CLEARANCE CERTIFICATE NO. M140968

NAME: (Principal Investigator)	Ms Lebohang Etheldreda Saohatse
DEPARTMENT:	Occupational Therapy Tshepo-Themba Private Hospital Private Practice, Soweto
PROJECT TITLE:	Experience and Perceptions of Clients with Major Depressive Disorder around their return to work
DATE CONSIDERED:	03/10/2014
DECISION:	Approved unconditionally
CONDITIONS:	
SUPERVISOR:	Matty van Niekerk
APPROVED BY:	Professor Cleaton-Jones, Chairperson, HREC (Medical)
DATE OF APPROVAL:	03/11/2014

This clearance certificate is valid for 5 years from date of approval. Extension may be applied for.

DECLARATION OF INVESTIGATORS

To be completed in duplicate and **ONE COPY** returned to the Secretary in Room 10004, 10th floor, Senate House, University.
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 resubmit the application to the Committee. **I agree to submit a yearly progress report**.

Principal Investigator Signature Date

PLEASE QUOTE THE PROTOCOL NUMBER IN ALL ENQUIRIES

APPENDIX I

Clinix
TSHEPO-THEMBA
PRIVATE HOSPITAL

30 September 2015

To whom it may concern

Re: Permission to conduct research to Ms Lebohang Saohatse at Clinix Tshepo Themba Private Hospital

This letter serves as permission to the above to conduct research on the experience and perception of clients with major depressive disorder around their return to work. Permission has been granted to conduct this research on an outpatient basis.

Kind regards

Zubair Coovadia

Hospital Manager

Clinix Tshepo-Themba Private Hospital
C/O Elias Motsoaledi Rd & Braamfischer
Ext. Soweto. P.O Box 2935, Florida, 1710,
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Dr. KOP Matseke (CEO), Dr. B Thulo (Chairman), Mr. R Shih (CFO)
Company Secretary: Ms. D Dickson. Registration No:1994/007606/07

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APPENDIX J

Enos M. Ramano

BOccTher (Medunsa) Dip Voc Rehab (Pret) MOccTher (Pret) CAMAG (ABIME)

PR.No. 6613551

HPCSA No. OT 0026336

Occupational Therapist

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2047

Consulting Rooms:
Life-Line Sessional rooms
Clinix Private Hospital
Soweto
Cell: 0825742720

27 October 2014

To whom it may concern

I, Enos M. Ramano, owner of the E.M. Ramano Practice, hereby give Lebohang Saohatse permission to conduct a study on 'Experience and perceptions of clients with Major Depressive Disorder' at my practice.

Miss L. Saohatse is known to me and she is the full time employee at the practice. Thus she may conduct the study upon approval by the ethics committee from the University of Witwatersrand, Johannesburg and the University of Witwatersrand Research Committee.

Regards

ENOS M. RAMANO
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Mr. Enos M. Ramano