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Exploring the Development of Self-Efficacy to Impact Discharge Preparedness in Major Depressive Disorder After Engaging in an Occupational Therapy Interactive Group Model Intervention

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UNIVERSITY OF THE
WITWATERSRAND,
JOHANNESBURG

EXPLORING THE DEVELOPMENT SELF-EFFICACY TO IMPACT DISCHARGE PREPAREDNESS IN MAJOR DEPRESSIVE DISORDER AFTER ENGAGING IN OCCUPATIONAL THERAPY INTERACTIVE GROUP MODEL INTERVENTION

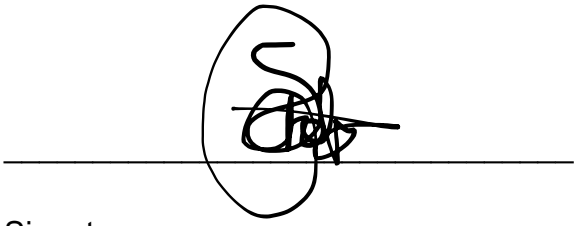
Charis Frances Stols

Dissertation submitted to the Faculty of Health Sciences,
University of the Witwatersrand, Johannesburg,
in fulfilment of the requirements for the degree of Master of Science in Occupational Therapy

Johannesburg, 2025

DECLARATION

I, Charis Stols (née Papageorgiou), declare that this research report is my own work. It is being submitted for the degree of Master of Science in Occupational Therapy at the University of Witwatersrand, Johannesburg. It has not been submitted before for any degree or examination at this, or any other university.



Signature

Signed on 25 August 2025

PLAGIARISM DECLARATION TO BE SIGNED BY ALL HIGHER DEGREE STUDENTS

I, Charis Stols (nee Papageorgiou) (Student number: 1353958), am a student registered for the degree of Master of Occupational Therapy in the academic year, 2023-2024. Plagiarism declaration

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ABSTRACT

Introduction: This study explored the development of self-efficacy and discharge preparedness in Mental Health Care Users (MHCUs) diagnosed with Major Depressive Disorder (MDD) after participating in a closed Occupational Therapy Interactive Group Model (OTIGM) group intervention over four days at a private, acute psychiatric hospital in South Africa. Given the limited post-discharge support, enhancing self-efficacy is vital for transitioning home to promote long-term recovery and potentially reducing readmissions. **Method:** A convergent mixed methods design was used to explore change in self-efficacy and discharge preparedness following participation in OTIGM intervention. The quantitative strand (n=78) employed a longitudinal approach, to identify change in pre- and post-test scores from the Mental Health Self-Efficacy Scale (MHSES) and discharge preparedness ratings. The qualitative strand (n=10) utilised semi-structured interviews, analysed using directed content analysis, exploring the perception of the influence of OTIGM intervention on self-efficacy to impact discharge preparedness, how the OTIGM intervention fostered self-efficacy and influenced perceptions of discharge readiness. **Results:** The findings revealed a positive correlation between improved MHSES scores and increased discharge preparedness. Qualitative findings highlighted the development of all four sources of self-efficacy (mastery, affective states, vicarious experience and verbal persuasion). Additionally, evidence of self-agency and the positive impact of the hospital environment was found. The research identified ambivalence towards discharge, reflecting both hope and hesitancy about transitioning to the home environment. **Conclusion:** This study provides evidence that OTIGM enhances self-efficacy and discharge preparedness in MHCUs with MDD. Underscoring the value of closed-group occupational therapy in fostering self-agency, promoting mental health self-management, and supporting community reintegration after acute psychiatric admission.

Key words: Discharge preparedness, Major Depressive Disorder (MDD), Mental health Mental health, Mental health self-efficacy (MHSE), Mental health self-efficacy scale (MHSES), Occupational Therapy Interactive Group Model (OTIGM), Self-Efficacy.

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DEFINITION OF TERMS

Term	Definition
Community reintegration	Community reintegration process of individuals, particularly those with disabilities, successfully returning to and participating in their communities, occupations through access to necessary resources and support systems (Tomlinson *et al.*, 2016).
Discharge preparedness	Discharge preparedness is an individual's perception of their own readiness to be discharged from a healthcare facility, including medication, access to resources, and social support, effectively manages post-discharge care (de Witt *et al.*, 2021).
Group therapy	Group therapy uses distinct knowledge and leadership techniques to promote learning and skill development throughout an individual's lifetime, utilising group dynamics and social interaction (AOTA, 2020).
Illumination	In the context of the OTIGM, illumination refers to when the therapist draws the group's attention to emotional or behavioural reactions during the session, helping members reflect on and make sense of their responses and group interactions (Fouché, 2021).
Facilitator	In the context of this research study, the facilitator is the occupational therapist who is facilitating the OTIGM intervention.
Leading from behind	In the context of OTIGM this describes the facilitator's role as a responsive by guiding group processes without imposing direction, allowing members to express needs and shape therapeutic engagement organically (Fouché, 2021).
Major depressive disorder (MDD)	Major depressive disorder is a mood disorder defined by a depressed mood or anhedonia, along with at least four other symptoms, lasting for at least two weeks and causing significant distress or impairment in functioning (APA, 2013).
Mental Health	Mental illness is a cause of disability which affects a person's ability to participate in their roles and perform the everyday tasks that are valuable to them. Thus, mental health is a sense of wellbeing, confidence, and self-esteem. It is psychological, social and emotional well-being, which allows participation in day-to-day life (South Africa, 2002).
Mental Health Care User (MHCU)	Any person, who has poor mental health, which detrimentally affects their occupational performance, receiving care, treatment and/or rehabilitation services that are used to enhance mental health status (South Africa, 2002).
Mental health self-efficacy (MHSE)	Mental health self-efficacy is a person's perceived ability to manage their mental health symptoms namely stress, depression and anxiety (Clarke *et al.*, 2014).
Mental health self-efficacy scale (MHSES)	The Mental health self-efficacy scale is a 6-question Likert scale self-questionnaire based on Bandura's Guide for Constructing Self-efficacy Scales within a specific domain of Mental Health to specifically quantify a MHCUs ability to cope with symptoms of stress, anxiety, and

	depression (Clarke *et al.*, 2014).
Model of Human Occupation (MOHO)	An occupation-based framework guiding occupational therapy practice, offering an integrative perspective on how human occupation is structured, and carried out in daily life (Kielhofer & Forsyth, 1997).
Occupational performance	Occupational performance is the successful completion of a chosen occupation, achieved through the dynamic interaction between the MHCU, their environment, and the occupation itself (AOTA, 2020).
Occupational therapy interactive group model (OTIGM)	The Occupational therapy interactive group mode is a model developed by a South African occupational therapist and a psychologist in the 1980s, based on Yalom's group theory, which was further refined by Fouché in 2021 as the OTGIM (Fouché, 2021).
Occupational Therapy	Occupational Therapy makes use of everyday activities with individuals or groups to enhance or enable their participation in everyday life so that functioning is optimised (AOTA, 2020).
Occupations	Occupations are every day, meaningful activities that individuals engage in alone, with family, or within communities to occupy time and bring purpose to life, encompassing areas like daily living tasks, health management, rest, work, education, play, and social participation (AOTA, 2020).
Self-efficacy	Self-efficacy is an individual's perceived ability to positively judge their own capability to manage and overcome challenges (Bandura, 1988).

ACRONYMS AND ABBREVIATIONS

Acronyms	Meaning
ADL	Activities of daily living
ANOVA	Analysis of variance
DP	Discharge preparedness
DSM-IV	Diagnostic and Statistical Manual of Mental Disorders, fifth edition
ECT	Electro-convulsive therapy
IADL	Instrumental Activities of daily living
ICD-10	International Classification of Diseases, 10th Revision
IQR	Interquartile range
MDD	Major depressive disorder
MDT	Multidisciplinary team
MHCU	Mental Health Care User
MHSE	Mental health self-efficacy
MHSES	Mental health self-efficacy scale
MOHO	Model Human Occupation
NHI	National Health Insurance
OT	Occupational therapy
OTIGM	Occupational therapy interactive group model
QUAL	Qualitative
QUAN	Quantitative
SA	South Africa
SD	Standard deviation
SE	Self-efficacy
VdTMoCA	Vona du Toit Model of Creative Ability

CHAPTER 1: INTRODUCTION

1.1. Introduction to the study

Depressive disorders, including Major Depressive Disorder (MDD), are a leading cause of disability globally; in South Africa, this burden is further exacerbated by widespread undiagnosed and untreated symptoms, leaving a significant portion of the population experiencing depressive symptoms in the absence of a formal mental health diagnosis (Burns, 2008; Craig *et al.*, 2022). MDD is associated with significant functional impairments that effect occupational engagement, social participation, emotional regulation, and cognitive functioning (APA, 2013). Occupational deprivation following discharge from and acute psychiatric hospital may result when there is limited discharge planning and referrals to outpatient services (Donisi *et al.,* 2016). Contributing to the "revolving door phenomenon," where poor continuity of care and inadequate post-discharge support may result in repeated hospitalisations (Petersen & Lund, 2012). Especially since carry-over of skills and reintegration into the community are key components of functional recovery of MDD (de Witt, 2021). In the private health sector in South Africa, the length of inpatient admission is often limited by medical aid funds rather than therapeutic gains with a focus on the biomedical model leading to premature discharge with limited funds for post-discharge care (Mahaffey *et al.*, 2015; Statistics South Africa 2020). Therefore, it is essential to improve discharge preparedness and self-management strategies during inpatient admissions to mitigate relapse (Hegedüs *et al.*, 2020; Petersen & Lund, 2012).

Interventions that promote self-efficacy have been linked to reduced risk of relapse, as individuals who feel empowered to make decisions about their lives are more likely to adopt behaviours that support long-term mental health (Cole, 2018; Benatti *et al.*, 2023). Self-efficacy refers to an individual's belief in their ability to manage and overcome challenges (Bandura, 1977) and Mental health self-efficacy (MHSE) more specifically describes the belief in managing and coping with mental health challenges (Clarke *et al.*, 2014; Ngooi *et al.*, 2022). Research has indicated that individuals with higher self-efficacy tend to experience better mental health outcomes, demonstrating resilience in managing

stress (Rabani *et al.*, 2011). Within occupational therapy, self-efficacy informs personal causation, volition, and engagement in meaningful occupations identifying it as a key factor in functional outcomes (Taylor *et al.*, 2023; de Witt *et al.*, 2021).

Occupational therapy interventions aim to restore occupational balance, support role resumption, and rebuild routines that are often disrupted by MDD. Research has shown links between task-based occupational therapy groups and improvements in MHSE and wellbeing at discharge (Ngooi *et al.*, 2022). The Occupational Therapy Interactive Group Model (OTIGM) published by Fouché (2021) is a socioemotional group intervention that uses a client-centred approach to encourage reflection, skill application, and social interaction facilitated through group dynamics, active engagement in experiential activities and (Davidson, 2018; Fouché, 2014). The interactive nature of the OTIGM supports interpersonal skill development, peer encouragement and personal autonomy for change which are critical for improving quality of life and reducing risk of relapse in individuals with MDD (de Witt *et al.*, 2021; Fouché, 2021).

The OTIGM is currently used in both South African private and public mental health services and taught in South Africa universities, there is currently limited outcome-based research on the OTIGM (Meyer, 2020). As South Africa moves toward implementing the National Health Insurance (NHI), which aims to reduce inequality and increase access to care, occupational therapy must demonstrate its value through evidence-based practice (South Africa, 2023; Evans-Lacko *et al.*, 2018). Specifically, highlighting the contribution of group-based occupational therapy interventions, like the OTIGM, in the recovery, reintegration, and sustainable discharge outcomes in the treatment of MHCUs diagnosed with MDD.

This dissertation explores how the OTIGM may support the development of MHSE and discharge preparedness in MHCUs diagnosed with MDD in an acute, private in-hospital psychiatric setting. Therefore, contributing evidence on the value of the OTIGM in improving discharge outcomes and supporting continuity of care, with relevance to the broader transformation of the South African healthcare system under the NHI.

1.2. Research problem

Following an acute admission to a private, inpatient psychiatric hospital in South Africa, many MHCUs with MDD experience limited continuity of care due to short hospital stays dictated by medical aid constraints, limited discharge planning and disappointment with post-discharge reality (Hegedüs *et al.*, 2020, de Witt, 2021). These challenges contribute to high readmission rates which continue to burden both the healthcare system and their community when MHCUs are discharged without the skills and confidence needed to manage their mental health independently (Petersen & Lund, 2012). Therefore, promoting MHSE during inpatient care may enhances MHCUs' capacity to manage MDD symptoms post-discharge. Occupational therapy interventions promote functionality and independence. Furthermore, the OTIGM, provides opportunities to practice of coping strategies and engage in experiential activities within a social context and social impairment which are key symptoms of MDD (Fouché 2021, Davidson 2018). There are currently limited studies using outcome-based research on the OTIGM (Meyer, 2020). Therefore, this study aims to close the gap by investigating the perceived impact of the OTIGM on self-efficacy and discharge preparedness in MHCUs with MDD by providing practice-based evidence using the MHSES as an outcome-based measure for the OTIGM group intervention. Especially with the introduction of the NHI within the South African context to advocate for the inclusion mental health occupational therapy services and, contribute to the advancement of occupational group therapy practice.

1.3. Research purpose

The purpose of this study was to identify how the OTIGM group intervention influences MHSE using the MHSES tool. This study further explored how the OTIGM intervention influenced self-efficacy to impact a MHCU diagnosed with MDD at an acute, private psychiatric hospital in South Africa. In essence, this study highlights the OTIGM's role to potentially support long-term therapeutic benefits beyond the acute psychiatric setting. The research question, aim and objectives are linked to the purpose of the study and are outlined below.

1.4. Research question

How does participation in the OTIGM group intervention influence MHSE and discharge preparedness in individuals with MDD admitted to a private acute psychiatric inpatient Hospital in South Africa?

1.5. Research aim

To explore the development of self-efficacy and discharge preparedness in MHCUs with MDD after participating in an OTIGM group intervention over 4 days at a private acute psychiatric hospital in South Africa, using a convergent mixed methods design.

1.6. Research objectives

Quantitative objectives:

Objective 1: To determine the change in self-efficacy, using the MHSES, and the change in discharge preparedness in MHCUs with MDD after participating in the OTIGM intervention.

Null hypothesis: There will be no change in MHSES scores for self-efficacy and no change in discharge preparedness in MHCUs with MDD following OTIGM intervention at a private acute inpatient psychiatric setting in South Africa.

Objective 2: To determine the effect of demographic factors on the change in self-efficacy and the change in discharge preparedness in MHCUs diagnosed with MDD following OTIGM.

Null Hypothesis: There is no statistically significant relationship between demographic factors and the change in MHSES scores following OTIGM intervention at a private acute inpatient psychiatric setting in South Africa.

Objective 3: To determine if a correlation exists between self-efficacy and discharge preparedness in MHCUs diagnosed with MDD after participating in OTIGM intervention.

Null hypothesis: There is no statistically significant correlation between MHSES scores for self-efficacy and discharge preparedness ratings after the OTIGM intervention at a private acute inpatient psychiatric setting in South Africa.

Qualitative Objective:

Objective 4: To explore the perceived impact of the OTIGM intervention on self-efficacy to impact discharge preparedness among MHCUs diagnosed with MDD.

1.7. Justification of study

The OTIGM is a type of group intervention that is intentional about the group dynamics and interpersonal relationships, active engagement in activities and personal autonomy for change (Fouché, 2014). Self-efficacy is developed through mastery, affective states, vicarious experience and verbal persuasion (Bandura, 1977). Due to the interactive nature of the OTIGM, there seems to be an overlap with self-efficacy literature with respect to the role of social interaction and experiential activities in achievement, emotional experiences, modelling, and feedback. This study builds on the theoretical links between self-efficacy and the OTIGM within the context of MHCUs diagnosed with MDD by exploring the development self-efficacy after participating in the OTIGM intervention within an acute psychiatric setting.

Meyer (2020) highlighted the lack of evidence-based research on the OTIGM, despite its widespread use in both private and public sectors in South Africa. A convergent mixed-method design offered an opportunity to gather holistic, in-depth data by incorporating both quantitative and qualitative data (Creswell, 2015). Combining quantifiable evidence with subjective perspectives allowed for a comprehensive understanding of the impact of the closed OTIGM group intervention over a 4-day period. Previous research by Ngooi *et al.* (2022), found a positive correlation between occupational therapy activity-based groups and MHSE at discharge. Therefore, this study extended the research to focus on the impact of the OTIGM on self-efficacy of dealing with mental health symptoms. Preparedness for discharge is a valuable addition to the study due to challenges faced at reintegration for MHCUs with MDD (de Witt *et al.*, 2021). Thus, quantitatively used Bandura's (1977) Social Learning Theory to explore the influence of MHSE on discharge preparedness. The influence of MHSE on discharge preparedness was studied through analysis of change from pre- to post- OTIGM intervention results using the MHSES developed by Clarke *et al.*, (2014) and a subjective rating of discharge preparedness.

Including a qualitative strand was particularly valuable, since self-efficacy and perceived preparedness for discharge are subjective concepts, making it essential to go beyond numerical data alone as the qualitative findings reflect on MHCUs' perspectives and expansion of their personal experience in the OTIGM group. The quantitative and qualitative data were collected and analysed concurrently and then examined in discussion to address the relationship between self-efficacy and discharge preparedness following the engagement in OTIGM intervention (Creswell, 2015). This study is valuable in assessing the effectiveness of the OTIGM intervention in prompting self-efficacy for managing mental health symptoms, ultimately supporting MHCUs in their recovery, readiness for discharge and their transition back into their communities. Therefore, this study strengthens evidence-based practice of occupational therapy group interventions to ensure that MHCUs are effectively equipped for life beyond acute private psychiatric hospital admission.

1.8. Organisation of dissertation chapters

In conclusion, this first chapter provided the background related to the development of the research problem to provide evidence for how the OTIGM model supports MHCUs, diagnosed with MDD, discharge process at a private hospital in South Africa, which resultantly developed the aim of this study. Chapter 2 provides an in-depth understanding of literature related to the intersection of theory of the OTGIM, self-efficacy, discharge preparedness in the context of MDD and further highlights the research gap addressed by this study. Chapter 3 provides the details related to the research design and methods used. Both Chapters 3 and 4 are divided into quantitative and qualitative strands to address the objectives of this study. Thereafter, Chapter 5 reflects on the literature review with a synthesises of the findings from both quantitative and qualitative strands, to address the study's aim and objectives. Finally, Chapter 6 concludes the dissertation and highlights recommendations for further research in this field. The Appendices provide the ethical documentation, data collection procedure and comprehensive data analysis results.

CHAPTER 2: LITERATURE REVIEW

2.1. Introduction

2.1.1. Overview of literature review

This literature review discusses an overview of the impact of the Occupational Therapy Interactive Group Model (OTIGM) on Mental Healthcare Users (MHCUs) with Major Depressive Disorders (MDD). The review further explores the link between Mental Health Self-Efficacy (MHSE) and preparedness for discharge to reintegrate functionally into South African communities after admission in an acute psychiatric setting. The literature explores the use of the Mental Health Self-Efficacy Scale (MHSES) as an outcome measure to provide evidence for OTIGM intervention. The chapter further discusses and summarises the theoretical underpinnings of Fouché's OTIGM (2021), Bandura's theory of self-efficacy (1977), Occupational Therapy Models such as the Model of Human Occupation (MOHO) (Kielhofner & Forsyth, 1997) in meeting the needs of MHCUs with MDD. The literature review establishes the foundation for the deductive qualitative analysis and serves as a platform for interpreting the findings in relation to existing research.

2.1.2. Methodology of literature review

To ensure adequate background regarding the impact of OTIGM on MHSE and discharge preparedness the following search engines were included: Francis & Taylor online, PubMed, Google Scholar, and PsycINFO. Key words and phrases when gathering information for the literature review included: "Occupational Therapy Interactive Group Model", "Self-efficacy", "Occupational therapy AND Discharge", "Occupational therapy AND Self-efficacy" "Readiness for discharge", "Self-efficacy AND Depression", "Mental health AND South Africa". Literature from the past 10 to 15 years was reviewed, with priority given to English-language sources published within the last 5 years. Seminal works and historical contributions were also included where relevant to provide foundational context. This review further included grey literature such as the researcher's own experience from facilitating OTIGM groups, government policies, websites as well as

course and study notes. Both Local (South African) and international resources and journal articles were used in gathering information for this chapter.

2.2. Major depressive disorders within the South African context

Globally, the spectrum of depressive disorders, including MDD, is considered to be the largest contributor towards disability, which is mirrored in the South African context where mental illness, surpassing even HIV, highlights the mental health epidemic and need for action (Craig *et al.*, 2022; Evans-Lacko *et al.*, 2018; South African Department of Health, 2023). As per the Diagnostic and Statistical Manual of Mental Disorders, fifth edition (DSM-5), MDD is a subclassification of depressive disorders which includes both acute and recurrent episodes and describes the prevalence of psychotic features and remission status (APA, 2013). According to South African Department of Health (2023) almost a sixth of the South African population reported being diagnosed with a mental health condition and/or a substance use disorder, of which 3.9% were diagnosed with depressive disorders. In South Africa mental health is widely influenced by the cumulative factors of the socio-economic environment, such as poverty, joblessness, lack of access to health and education services (South African Department of Health, 2023). A South African study found that females are 1.75 times more likely than males to experience MDD in their lifetime (Tomlinson, 2009). The DSM-5 MDD diagnosis criterion makes special reference to the impact of “bereavement, financial ruin, losses from a natural disaster, a serious medical illness or disability” (APA, 2013, p. 125) on mood, which are widespread in the South African context. The MHCUs experience of stigma due to social exclusion, reduced productivity, and loss of income, leading to an endless loop of the country’s increased health expenditure, unemployment, poverty, and violence, which in turn reflects that the state of the country exacerbates experiences of depression (South African Department of Health, 2023).

One of the key diagnostic criteria for many mental health diagnoses, including MDD, according to the DSM-5, is “clinically significant distress or impairment in social, occupational, or other important areas of functioning” (APA, 2013, p. 161). Evidently describing occupational performance areas, which are the underpinning of occupational

therapy; therefore, making occupational therapists key role-players in the assessment and treatment of MHCUs. Seminal occupational therapy literature promotes a person's ability to 'do' daily tasks to 'be' able to live and 'become' part of their community (Wilcock, 1999). Wilcock's, 1998 occupational therapy concepts are observed through components such as motivation, roles, routines, and habits which are adversely influenced by MDD (Taylor *et al.*, 2023). Additional criteria specific for MDD include loss of interest in pleasurable tasks, depressed mood, loss of energy, sleep disturbances, feelings of worthlessness and changes in psychomotor functioning and/or concentration. These abovementioned diagnostic criteria result in lack of engagement in occupations with decreased enjoyment and drive which lends itself towards occupational deprivation (Wilcock, 1999). Whereas success in daily life tasks lessens the burden of care on the MHCUs community and the health system as they are more independent and self-sufficient (Petersen & Lund, 2012).

Highlighting the importance of continued support beyond discharge, as reflected in the term the 'revolving door phenomenon' which describes a cycle of recurrent hospitalisations experienced by MHCUs (Cole, 2018; Petersen & Lund, 2012). Underscoring the critical need for support at the grassroots level within the MHCUs context to promote continuity of care to prevent repeated multiple readmissions (Ober *et al.*, 2022; Petersen & Lund, 2012). Continued support after discharge is important as evidence has found a decline in engagement and performance in daily tasks post-discharge when MHCUs did not receive out-patient occupational therapy intervention (Silaule, 2016). In the private medical sector, medical aid funding covers healthcare costs such as hospitalisation, treatments and medicine, which in South Africa, is currently supplied by private institutions at individuals' own cost with varying levels of coverage depending on the monthly contribution (Discovery Health Medical Scheme, 2024). In South Africa 15.2% of the population have access to private medical aid (Statistics South Africa 2020). Therefore, private medical aids offer MHCUs access to in-hospital services and the level of out-of-hospital funding is based on the level of their medical aid coverage (Meyer, 2020). In a private, acute hospitalisation the length of stay for MHCUs diagnoses with MDD is most often determined by the psychiatrist and discharge occurs once acute depressive symptoms are resolved rather than recovery of functional outcomes (de Witt

et al., 2021). Based on these shortcomings, the South African healthcare system is undergoing a shift towards the NHI to contribute towards bridging the national and global treatment gap for mental illness (Evans-Lacko *et al.*, 2018). Aiming to provide more accessible and holistic healthcare services, aligning with the 2002 Mental Health Care Act No.17 to shift focus to rehabilitative and community-based care, thereby deinstitutionalising treatment and care of MHCUs (South Africa, 2002). The NHI was officially signed by South African President Cyril Ramaphosa, which was published in the Government Gazette on the 16th of May 2024 (South Africa, 2023).

Occupational therapy research has shown efficacy in community and continued care post discharge services reduce the number of re-admissions and length of stay (Mahaffey *et al.*, 2015; Plastow, 2015). However, prescribed minimum benefits of medical aids focus in-patient psychiatric care resulting in MHCUs being responsible for independently funding appropriate multidisciplinary out-patient services to promote reintegration after discharge (Silaule, 2016). Therefore, MHCUs are only likely to access psychiatric interventions during in-hospital admissions, which may limit the application of skills to their real-world environment. Shifting the focus to the grassroots level may reduce in-hospital readmission therefore benefitting medical aids by reducing health care costs (OTASA, 2021). As currently out-patient therapy largely focuses on medication and symptom management following a biomedical model (Plastow *et al.*, 2015; Silaule, 2016). Therefore, it is important to make a significant impact on intervention while MHCUs are admitted at in-patient facilities which are covered by the MHCUs medical aid (Mao *et al.*, 2024; Ramano, 2017). However, one study exploring readmission, highlighted that unrealistic expectations upon returning home and difficulty translating skills learnt to daily life contributed to relapse, and recommended further investigation into out-patient, post-discharge support groups to better assist clients in their home environments (de Witt, *et al.*, 2021). Psychiatric day hospitals may be beneficial to serve as a bridge in facilitating the application and generalisation of therapeutic skills, as MHCUs do not stay overnight at the hospital (Masango *et al.*, 2024). Therefore, MHCUs are provided with opportunities to practise skills in their personal and social contexts (Ober *et al.,* 2022). However,

according to a scoping review by Masango *et al.*, (2024) there is limited literature on occupational therapy groups, including the OTIGM, in the day-hospital setting.

In the study of Hegedüs *et al.* (2020) a contradictory systematic review found that interventions focused on transition to the community had the same outcomes whether the MHCUs did or did not receive support and noted that it may be due to the lack of research, proper outcome-based measures to track progress and lack of transitional-specific interventions. Revealing the importance of providing evidence for effective ways to facilitate discharge readiness after acute admission to psychiatric hospital to promote effective out-patient services in both the private and public healthcare sectors in South Africa, to reduce strain on hospitals and improve accessibility of mental health services. Achieving these outcomes requires not only system-level interventions, but also equipping MHCUs with the skills, confidence, and resilience needed to navigate the challenges of reintegration, especially in the South African context, where access to post-discharge services is limited and continuity of care is often disrupted (Petersen & Lund, 2012).

2.3. Major depressive disorder linked to Self-Efficacy

Self-efficacy was first introduced by Bandura in 1977 as the re-engagement in enjoyable and meaningful activities, reflecting behavioural change. Perceived self-efficacy is important for individuals in investigating shifts in behaviour and positive responses to MHCUs engaging in health promoting behaviours (Bandura, 1977).

Self-efficacy is defined as an individual's ability to positively judge their own capability to manage and overcome challenges (Bandura, 2006).

Self-efficacy is developed through four sources: mastery of experiences, physiological and emotional states, vicarious experiences and verbal persuasion (Bandura, 1977). Mastery of experiences builds self-efficacy through personal achievements; vicarious experiences develop by observing others succeed; verbal persuasion reinforces beliefs through encouragement and support, and physiological and affective state influences are based on managing emotional responses to challenges (Bandura, 1977). A strong sense of self-efficacy enables individuals to manage negative challenges, whereas low self-efficacy has the opposite effect, making individuals feel less capable of addressing similar

challenges (Rabani *et al.*, 2011). The term MHSE more narrowly explores MHCUs' confidence in their ability to manage their mental health problems, specifically stress, anxiety, and depression (Clarke *et al.*, 2014). Highlighting that high self-efficacy provides protection against psychological stressors due to having an improved response to stress, which may lessen the severity of mental health disorders (Rabani *et al.*, 2011).

Previous research, as early as 1977 (Bandura), showed that self-efficacy improves health promoting behaviours such as a reduction in smoking, alcohol and drug use, and weight loss. According to Rabani, Bavojdan, Towhidi and Rahmati (2011) self-efficacy is an identifier of mental health recovery and improved well-being as individuals with high self-efficacy are able to manage and assert control in stressful situations. Contrarily, individuals with low self-efficacy, believe they cannot manage stressful events, which cause or lead to high levels of anxiety resulting in poor mental health (Bandura, 1988). Increase in self-efficacy improved medication adherence and independent health management of chronic illnesses (Khalifeh *et al.*, 2023). Furthermore, interventions focused on self-efficacy were found to be linked to reduce risk of relapse (Benatti *et al.*, 2023; Gopinath *et al.*, 2007), highlighting that personal belief plays a role in recovery, as individuals who feel empowered to make decisions about their lives are more likely to engage in behaviours supporting long-term mental health (Cole, 2018). Whereas MHCUs who were disappointed due to unmet expectations after returning home from their first acute psychiatric admission identified that their residual MDD symptoms worsened and their problems persisted (de Witt *et al.*, 2021).

Although the initial literature review did not emphasise self-agency, the qualitative analysis revealed it as a key theme in the OTIGM intervention as participants frequently described a sense of personal empowerment and autonomy, suggesting that self-agency is an important construct which is developed in the OTIGM intervention. Self-agency relates to constructs such as locus of control, autonomy, and personal responsibility (Tapal *et al.*, 2017; Yalom & Leszcz, 2005). Grounded in Bandura's social cognitive theory, agency is defined as "control over the nature and quality of one's life" (Bandura, 2001, p. 1). Self-agency extends beyond self-efficacy, transforming belief in one's ability to succeed into

responsibility to take action towards desired outcomes (Cole, 2018). It is therefore unsurprising that self-efficacy is one of the four core features of self-agency, along with *intentionality, forethought* and *self-reactiveness* (Bandura, 2001). *Intentionality* involves setting and committing to goals; *forethought* relates to action based on anticipation of future outcomes; and *self-reactiveness* is regulating behaviour in alignment with personal values, beliefs, and purpose (Bandura, 1986; Cole, 2018). A study with MHCUs diagnosed with psychosis, found that promoting MHCUs' choices in treatment planning improved self-agency in recovery and strengthened relationship between the health professional and the MHCU (Oedegaard *et al.*, 2020). The limited studies on self-agency in mental health, particularly regarding MDD, may be attributed to the challenges in assessing this abstract construct (Tapal *et al.*, 2017). One study attempted to fill this gap by developing the Sense of Agency Scale (SoAS) however this study found no significant correlation between self-agency and the general self-efficacy (Tapal *et al.*, 2017), despite the expectation that self-efficacy would be foundational to self-agency. Cole (2018) highlighted the goal of independent functioning in occupational therapy interventions, therefore understanding what impacts both self-agency and self-efficacy.

The distinctive term MHSE highlights a person's "confidence in their ability to manage their mental health problems" (Clarke *et al.*, 2014. pg. 2) thus allowing MHCUs to have improved outcomes once they are discharged. Evidence has indicated that self-efficacy is a gauge of mental health as it is associated with a reduction of psychosocial symptoms due to the belief that one is capable of managing stressful and/or negative events (Petersen & Lund, 2012; Rabani *et al.*, 2011). A recent study indicated the link between activity-based occupational group therapy and high mental health self-efficacy at discharge (Ngooi *et al.*, 2022). Therefore, self-efficacy is valuable and necessary within the field of occupational therapy to determine the MHCU's commitment to therapy and their application of skills to their own contexts post-discharge (Gage *et al.*, 1994).

Occupational therapists are experts in understanding a person's participation and performance in occupations to increase their independence and providing purpose to their daily lives to enable patients in becoming functional members in their community and

contexts (AOTA, 2020). Occupational therapists play a critical role in providing rehabilitation services as well as promotion, prevention, and curative areas within psychiatry. Part of formal and informal occupational therapy psychiatric assessments include evaluation of psychosocial client factors and performance skills impacting on a MHCU's occupational performance to find areas of intervention within emotional regulation, cognitive, communication, social and/or prevocational skills (AOTA, 2020). The client factors that collectively build resilience in MHCU's ability to deal with psychosocial stressors include self-efficacy forming part of 'experience of self and time'; locus of control, which is the belief of whether outcomes are based on personal control, and self-esteem, which is identifying positive and negative traits (AOTA, 2020; Bandura, 2006). Poor self-efficacy, lack of support, and low self-worth are identified as barriers in MHCUs' performance in daily occupations which negatively impact success post-discharge (Kelly *et al.*, 2010). The Model of Human Occupation (MOHO) expands on the above client factors through the 'human open system' model which describes the interplay between an individual's internal subsystem and external feedback from their environment (Kielhofner & Forsyth, 1997). One of the components of the internal subsystem is personal causation, which is defined as competence and belief in oneself to use skills for their desired effect, which can alternatively be defined as self-efficacy (Cole, 2018). Therefore, self-efficacy can be highlighted as an occurring component within occupational therapy intervention.

Since self-efficacy is a subjective construct, influenced by MOHO's internal subsystem, influenced by personal attributes, circumstances, and demographic factors (Kielhofner & Forsyth, 1997). Males exhibited higher self-efficacy levels after participating in a task-based occupational therapy group intervention compared to females (Ngooi, 2022). Boredom, loneliness, and levels of depression have been found to increase in older adults due to decreased capacity and fewer opportunities to engage in activities, leading to a reduction in self-efficacy (Taylor *et al.,* 2023). Younger individuals may exhibit greater adaptability by exploring their identity and relationships, while older adults may rely on past experiences and ingrained coping strategies that either support or hinder positive change (Erikson, 1998; Mao, 2024). Ngooi (2022) found no significant differences in self-efficacy based on education level or employment status; meaningful research on these

variables is limited. Potentially, higher levels education may improve problem-solving and coping skills, however it has also been linked to increased anxiety, possibly affecting self-efficacy (Mao, 2024). Unemployment and workplace stressors are prevalent in South Africa, impacting helplessness and limited self-belief (South African Department of Health, 2023; Tomlinson *et al.*, 2009). Ngooi (2022) found that married individuals had higher levels of self-efficacy due to supportive relationships, which was complemented by a South African study indicating that single or divorced individuals experienced greater challenges with post-discharge reintegration (de Witt *et al.*, 2021). These findings highlight the importance of social relationships, which have been identified as a key factor in promoting recovery and improving mental health outcomes (Tew *et al.*, 2012). Therefore, a supportive group environment allows MHCUs to explore how their personal demographics shape their experiences while engaging with others from diverse backgrounds, fostering improved social interaction and reinforcing the role of peer support in building self-efficacy (Yalom & Leszcz, 2005; Ngooi, 2022).

A study by Toledano-González *et al.* (2018) found evidence that group interventions indicated higher generalised self-efficacy scores over individual interventions within chronic mental health. In an acute psychiatric setting, self-efficacy was identified as an important component of group interventions to empower and improve the mental health and well-being of MHCUs (Ngooi *et al.* 2022). Evidence has suggested that group therapy reduces the use of healthcare services, improves medical outcomes, promotes self-efficacy, which often makes group interventions more effective than individual therapy as it allows for peer interaction (Yalom & Leszcz, 2005). The group environment highlights the valuable role of emotional support in helping individuals feel less alone in their experiences and fostering a sense of optimism about recovery (Radnitz *et al.*, 2019). Promotion of peer interaction provides for ‘better modulation of transference’ which means that the group can better manage emotional reactions, creating a constructive environment for independent skill learning amongst one another (Yalom & Leszcz, 2005). Furthermore, occupational therapy groups uniquely provide practical opportunities using task-related activities that produce a tangible or intangible end product for MHCUs to engage socially and develop interpersonal skills (AOTA, 2014). Additionally, since group

interventions facilitate positive interactions with the external environment and promote the identification of shared beliefs and collaboration, groups may in addition foster the development of self-agency (Bandura, 2001). Ngooi *et al.* (2022) describes how an occupational therapy task-group promotes each of the following four sources of self-efficacy: mastery experiences, vicarious experiences, verbal persuasion, and physiological and affective states; concluding that high self-efficacy was linked to activity-based group intervention. Group therapy within the occupational therapy context should be aimed at MHCUs finding and engaging in meaningful occupations and taking on meaningful roles in society (Cole, 2018).

2.4. Occupational Therapy Interactive Group Model (OTIGM)

The Occupational Therapy Interactive Group Model (OTIGM) in occupational therapy groups serves to improve attitudes towards mental health diagnoses and instil hope towards a meaningful life in an acute setting through unique opportunities allowing for application of skills which aligns with self-efficacy literature (Fouché, 2021; Davidson, 2018). The OTIGM was developed by a South African occupational therapist, De Beer, and a psychologist in the 1980s, based on Yalom's group theory, which was further refined by Fouché in 2021 as the OTIGM (Fouché, 2021). Occupational therapy provides activity-based interventions, which facilitates experiential learning, which differs from Yalom and Leszcz's, (2005) psychological approach, which consists of verbal-based groups (Davidson, 2018; Zedel & Chen, 2021). Other occupational therapy theories that inform group include the Model of Human Occupation (MOHO) (Kielhofner & Forsyth, 1997) and Vona du Toit Model of Creative Ability (VdTMoCA) (de Witt, 2014). The OTIGM is different from other long-established occupational therapy groups such as 'psychoeducation' or 'task-based groups' where group members engage in parallel with limited therapeutic use of social interaction and allows MHCUs the opportunity to practise skills and receive direct feedback from peers to translate their behaviour skills to their daily lives (Davidson, 2018; Fouché, 2021). Activity selection in the OTIGM is client-centred to highlight relevant themes to address the MHCUs challenges, which are explored through participation and experience rather than solely relying on discussion and information exchange (Fouché, 2021; Yalom & Leszcz, 2005). Thereafter, it is important to promote self-agency so that

the developments made in the group are more likely to carry over into daily life, in order to support change in the discharge environment (Cole, 2018).

The key components of OTIGM are explored below (Fouché, 2021).

- **Client-Centred Approach:** The OTIGM follows a client-centred approach, with therapeutic activities and interventions tailored to meet the needs of group members both individually and collectively.
- **Group Dynamics and Social Interaction:** Therapeutic activities are designed to promote group cohesion, social interaction, and the development of healthy relationships within a safe and supportive environment. The safe environment is what facilitates change to happen and therefore it is important to transition coping to the 'unsafe' community environment where MHCUs experience social exclusion due to stigma (South African Department of Health, 2023).
- **Yalom's Curative Factors:** The OTIGM incorporates Yalom's curative factors, such as instilling hope, developing group cohesion, and promoting self-disclosure. Therefore, promoting for a sense of mastery by facilitating the MHCUs motivation to take control, be proactive and therefore believe that change is possible (Yalom & Leszcz, 2005). These curative factors can be used skilfully at different phases of group forming to enhance therapeutic outcomes and facilitate personal growth.
- **Core Concepts of the OTIGM**
    - *Here and Now*: Is one of the keystone principles as it allows MHCU to bring awareness to their emotions, responses to others, and behaviour in the present moment, to create an opportunity for MHCUs to externalise their emotional state to be addressed within the group.
    - *Leading from behind:* Provides autonomy to group members and promoting self-efficacy reflecting the value of a client-directed approach.
    - *Group as a mini society*: The therapist simulates real-life social interactions, allowing group members to practice and develop healthy social skills in a supportive setting, allowing MHCUs to generalise skills more easily after discharge from the group.

- *Group as part of a microcosm* encouraging illumination amongst MHCUs to reflect social norms outside of the group setting.
- *Changes Taken Back to Society*: Insights and changes made within the group are generalised to MHCU's daily lives within the MHCU's community.
- *The Whole is Greater Than the Sum of its Parts*: Group members benefit from collective support, feedback and experiences shared within the group.

The OTIGM is taught at both undergraduate and post-graduate levels at universities in South Africa however only in the last five years has research on the OTIGM become more prominent. Two South African master's theses, Davidson (2018) and Meyer (2020), explored the OTIGM and provided original published literature created from the information on the model obtained through in-service training and attending courses. These courses by OT Grow (2022) were designed for mental health practitioners by a group of occupational therapists led by South African therapist, Louise Fouché. In 2021, Fouché coined the term OTIGM as previous studies inconsistently labelled the group therapy approach as 'Integrated Groupwork Model', 'Interactive Groupwork Model' or 'Interactive Occupational Therapy Group Model'. The OTIGM can be used in a both open and closed groups (Fouché, 2014).



Figure 2.1: The process of a group session within the Occupational Therapy Interactive Groupwork Model.

Each session is guided by a structured format, including a clear beginning, a central phase of focused activity, and a defined conclusion following the OTIGM framework illustrated in Figure 2.1. The session opens with an introduction and is followed by establishing group norms. Next, during the emotional meet, group members are encouraged to acknowledge their emotions and needs. The facilitator then selects a warm-up activity and uses a bridging discussion to connect the emerging insights to the session's theme, which is further explored in the main activity. After participation in the main activity, group members

engage in a reflective discussion allowing them to share their insights and experiences. Finally, the group session is closed with a summary and final reflection (Fouché, 2021).

The activities selected by the therapist are directed by a client-centred approach using clinical reasoning used to select appropriate means-to-an-end activities to address the 'here and now' needs of the group which overall identify socio-emotional themes. The facilitator selects therapeutic activities that facilitate opportunities for MHCUs to reach client-identified goals (Fouché, 2021). Common themes that have emerged in the researcher's four years of experience in OTIGM intervention have included forgiveness, self-esteem, letting go, perception, self-identity, conflict management, social skills, future planning and problem solving (to name a few). Flexibility in activity selection is important so it can be adapted at any point during the session due to problem spotting or emergence of new themes (Fouché, 2014). According to Kielhofner and Forsyth (1997), a group must be experienced as meaningful by the MHCU) in order to foster confidence, proficiency, and self-assurance. Encouraging autonomy through shared activity selection promotes group decision-making around themes and activities, aligning with a psychodynamic approach that supports the group in developing its own identity (Fouché, 2014).

An important cornerstone of the OTIGM is redirecting focus to the *here and now* to reflect on current actions and making changes in the moment, which links to Wilcock's (1999) principle of 'doing', allowing the MHCU to apply skills in the moment. Thus, the OTIGM is a tool that provides a defined structure and principles which provide a unique contribution to the field of mental health due to the focus on the therapeutic use of activity and activity evaluation (Marshall *et al.*, 2022). The OTIGM using Yalom's group principles facilitates the 'here and now' to implement client-driven skills (Fouché, 2021). Yalom's (2005) principles aim to shift MHCU's approach to psychosocial stressors from passive to reactive, which promotes internal locus of control and implementation of skills, therefore ultimately facilitating self-efficacy. The theoretical application of occupational therapy group models to self-efficacy principles namely mastery of experiences, vicarious experiences, verbal persuasion, physiological and emotional states reflect how the theory of the OTIGM may promote self-efficacy as explored in Table 2.1.

Table 2.1: A Table illustrating how the Occupational therapy interactive group model promotes the 4 sources of self-efficacy of Bandura's Social Learning Theory (Fouché, 2021)

Source of Self-Efficacy	***Application in OTIGM***	***Counterarguments***
Mastery of Experiences	• Therapeutic activities are designed to match and progressively challenge MHCUs' skills. • MHCU's practice new skills in a safe, supportive environment, experiencing success and building confidence.	• Group dynamics may lead to negative peer influence or social comparison, undermining individual confidence.
Vicarious Experiences	• MHCU's observe group members successfully completing tasks, enhancing their belief in their own abilities. • Universality of sharing success stories and coping strategies within the group.	• Skills and confidence gained in a group may not transfer effectively to real-world/community/home environments. • Focusing on the collective rather than individual needs. • Social comparison, if MHCU's perceive themselves as less competent compared to others.
Verbal Persuasion	• Therapists provide illumination and constructive and positive feedback. • Peer support and encouragement foster a supportive atmosphere through cohesion.	• MHCU's may become overly reliant on group validation, hindering the development of independent self-efficacy.
Physiological and Emotional States	• Norming and forming stages of the group process create a safe and non-judgmental environment, reducing anxiety. • Shifting through difficult emotions to positive ones in the here and now. • Activities that activate or relax physiological state.	• The effectiveness of OTIGM depends on the therapist's skill and the consistency of the group's supportive environment. • Social anxiety.

Table 2.1 demonstrates how the four sources of self-efficacy, mastery of experiences, vicarious experiences, verbal persuasion, physiological and emotional states, are applied to the OTIGM along with potential counterarguments. The OTIGM promotes mastery by selecting activities that challenge MHCUs and allow them to build confidence through success. Vicarious experiences are facilitated as MHCUs observe other group members' successes and share coping strategies, reinforcing belief in their own abilities. Verbal persuasion is encouraged through therapist feedback and peer support to create a supportive environment. Lastly, physiological and emotional states are created through a

safe, non-judgmental group environment to reduce anxiety and help MHCUs to manage their emotions. Table 2.1 also lists possible counterarguments such as negative peer influence, over-reliance on group validation, and challenges in transferring skills to themselves or everyday life situations.

Neglecting occupational deficits, poor discharge plan without community referrals, coupled with a short admission period, while MHCU is still experiencing acute MDD, may result in MHCU continuing to experience occupational deprivation when they return home, which increases the risk of re-admission (Donisi *et al.*, 2016). The OTIGM inherently focuses on improving functional outcomes within the MHCUs' daily responsibilities and familial and works roles. The OTIGM has the greatest focus on social participation which has been argued to be the most significant indicator of a MHCU's level of creative ability (de Witt, 2014; Fouché, 2021). Fouché (2021, pg. 64), highlighted that "once these skills have been mastered, the chances are good that long-term change has taken place". The OTIGM lives up to its 'interactive' name as the group format encourages group members to have influence on one another and engage with activities to facilitate opportunities for group members to express what is happening outside of the group to shift focus and incorporate these themes to be addressed in the group (Fouché, 2021).

A previous study on occupational therapy task-based groups, found that the level of participation alone does not influence self-efficacy, instead the MHCU needs to experience mastery and believe that their input may lead to success (Ngooi *et al.*, 2022). However, despite the interactive nature of the OTIGM, MHCUs with MDD may struggle to meaningfully engage and achieve mastery due to common symptoms such as isolation, withdrawal, and low self-confidence (APA, 2013; de Witt *et al.*, 2021). Additionally social expectation and stigma of mental health in the South African context contributes to reduced help-seeking and hesitation toward group therapy, which is often perceived as unfamiliar, unsafe (South African Department of Health, 2023; Yalom & Leszcz, 2005). Positive shifts in MHCUs perception occupational group therapy are often noted once MHCUs begin to engage, particularly among those with no prior experience (Ramano, 2017). Additionally, the limited awareness of MDT members on occupational therapy's

role in mental health may further hinder support for group-based interventions (Sarsak, 2022). These identified barriers to fully benefiting from group therapy, highlight the need for routine outcome measures within the OTIGM to provide evidence of its impact, inform clinical decision-making and advocate for its role in mental health.

As there remains limited published research on the OTIGM, it is important to provide practice-based evidence using outcome-based measures to advocate for its usefulness in the mental health continuum of care (Davidson, 2018). Routine outcome measures specifically within mental health, are important to advocate for services in the South African context. Meyer (2020) aimed to associate the lengthy Activity Participation Outcome Measure (APOM) based on Vona du Toit Model of Creative Ability (VdTMoCA) with the more time effective Patient Health Questionnaire 9 (PHQ-9) to provide evidence of the change in activity participation of MHCU's with MDD. Other studies have used both quantitative and qualitative data to provide practice-based evidence of occupational therapy activity-based groups (Ngooi *et al.*, 2022; Ramano, 2017). Thus, it is valuable to extend research towards the OTIGM as many self-efficacy principles are noted in the theoretical exploration of the model.

2.5. Mental Health Self-Efficacy Scale (MHSES) and need for outcome-based measures.

A MHCU's perceived ability to cope, sense of hope, connection to others, self-efficacy, empowerment, and self-esteem are indicators of resilience, however, these abstract concepts are difficult to quantify to measure outcomes (Casteleijn, 2010; Laird *et al.*, 2019). Thus, Bandura (2006) developed a 'Guide for Constructing Self-efficacy Scales' for other researchers to build self-report questionnaires to fit within a specific domain of functioning. Thus, the MHSES was developed by Clarke *et al.* (2014) to specifically quantify an MHCUs ability to cope with symptoms of stress, anxiety, and depression. Clarke *et al.* (2014) used the MHSES in a study to determine the efficacy of a mobile phone and web-based psychotherapy intervention among online-recruited individuals reporting symptoms of depression, anxiety, and stress. Proceeding studies, (Clarke *et al.*, 2014; Ngooi *et al.*, 2022; Zhou, 2022) used the MHSES to quantify MHSE to link to the

MHCU's mental health, reflecting that increased self-efficacy correlates with improved mental health.

The most recent National Mental Health Policy Framework and Strategic Plan 2023-2030 (South African Department of Health, 2023, p. 22) states that "the NHI will specifically include packages of care for mental health, in line with the evidence for the most cost-effective interventions". Casteleijn (2013) illuminated the need to recognise and measure the contribution of occupational therapy to receive recognition for the impact of occupational therapy on mental health and well-being. Another study further recommended that occupational therapy could promote unique contributions to MHCUs by identifying appropriate outcome measures to provide evidence for occupational therapy intervention (Wong *et al.*, 2022). According to the OTASA Annual Report, 'NHI readiness' must become an urgent area of discussion within occupational therapy (OTASA, 2019). In 2021 (OTASA), strides were made in the above-mentioned initiative; however, there is a further need for both researchers and clinicians to assist with evidence in defining what occupational therapy services can be delivered and the financial expense in correlation with ICD-10 guidelines. Disregarding the need for advocacy may result in the exclusion of occupational therapy services within the proposed structure of the NHI (Myezwa & Van Niekerk, 2013; OTASA, 2021).

2.6. Theoretical Frameworks

This study is grounded in a multi-theoretical approach, integrating Fouché's (2021) OTGIM, Bandura's (1977) Social Learning Theory on self-efficacy, and discharge preparedness in the context of occupational therapy literature of Kielhofner and Forsyth's (1997) Model of Human Occupation (MOHO). Which collectively provide a comprehensive lens to explore how the OTIGM intervention develops self-efficacy and discharge preparedness. Each of these theories have been outlined in the literature review therefore this section highlights the intersection of these theoretical frameworks and their role in shaping this study's design. Table 2.2. illustrates a structured comparison of the key concepts, group dynamics, therapeutic process, intervention strategies, goal setting and outcomes.

Table 2.2 The intersection on conceptual theories of the Occupational therapy interactive group model (OTIGM), Self-efficacy within Bandura's Social Learning Theory and Kielhofner's Model of human occupation (MOHO) within the group

Conceptual theories	***Occupational Therapy Interactive Group Model (OTIGM)*** (Fouché, 2021)	***Bandura's Self-efficacy Theory*** (Bandura, 1977, 2010)	***Model of Human Occupation (MOHO)*** (Cole, 2018; Kielhofner & Forsyth, 1997)
Key Concepts	Emphasises the dynamics of group interaction and communication to facilitate therapeutic outcomes.	Focuses on a MHCU's belief in their capability to perform tasks and achieve goals.	Explores the interplay between volition (motivation), habituation (roles and routines), and performance capacity in occupational engagement (environment, skills and application).
Group Dynamics	Focuses on the quality of interactions, communication patterns, and relationships and mutual understanding of therapeutic goals.	Recognises that self-efficacy beliefs can be shaped and reinforced through social interactions within groups.	Considers how group dynamics and social contexts influence MHCU's motivation, habits, and occupational choices.
Therapeutic Process	Utilises group activities, discussions, and illumination promoting skill development, emotional expression, problem-solving to promote long-standing change.	Encourages the use of modelling and guided practice, opportunities for mastery to enhance self-efficacy beliefs and promote behavioural change.	Focuses on helping MHCUs identify and pursue meaningful occupations, considering personal interests, values, and environmental factors.
Intervention Strategies	Includes a variety of group-based elements such as activities, discussions, facilitation/prompting techniques.	Incorporates four strategies such as mastery experiences, vicarious experiences, verbal persuasion, and physiological and affective states to promote adaptive behaviour.	Utilises occupation-focused interventions that address barriers to occupational engagement, build skills, and enhance the MHCU's sense of competence and autonomy.
Goal Setting	Collaboratively setting group goals that are aligned to MHCUs' occupational needs and aspirations.	Setting of challenging yet attainable goals to foster a sense of mastery and accomplishment.	Setting individual, occupation-based goals that align with MHCU interests, values, and societal roles '*just right challenge*'.
Outcomes	Aims for improved occupational performance, social participation, and overall well-being among group members.	Expects that increased self-efficacy will lead to greater persistence, resilience, and success in achieving occupational goals.	Anticipates changes in occupational engagement, satisfaction, and overall quality of life as MHCUs develop skills, establish routines, and pursue meaningful occupations.

The OTIGM emphasises group dynamics by using interactive activities to facilitate communication and problem-solving for lasting change (Fouché, 2021).While self-efficacy centres on building MHCUs' belief in their ability to achieve goals through mastery experiences, vicarious experiences, verbal persuasion, and physiological states to reinforce self-efficacy (Kielhofner & Forsyth, 1997), MOHO focuses on helping MHCUs engage in meaningful occupations by considering their personal values and environmental factors within a feedback loop. all three of these frameworks illuminate that change is built through 'doing'. Together, these theories underscore that change is fostered through action within the environment rather than just intellectual insight (Hitch *et al.*, 2014). MOHO has a component called personal causation under an umbrella of volition which can be mirrored to self-efficacy, therefore reflecting that self-efficacy is an existing concept in occupational therapy literature (Cole, 2018).

Table 2.2 illustrates the evidence of self-efficacy in occupational therapy, suggesting how structured group activities, support, and client-centred goal setting can enhance motivation, promote adaptive behaviour and support sustained engagement in therapeutic and occupational goals. These theories interact dynamically to explore the perceived real-world discharge outcomes after the closed-group OTIGM intervention, ultimately depicting how the MOHO provides the occupational lens, while self-efficacy explains belief, and OTIGM is the group-based intervention framework through which discharge preparedness is shaped. Ultimately, these frameworks guide the methodological approach of this study and informs the interpretation of findings to provide grounding for the objectives to identify convergent and divergent results.

CHAPTER 3: METHODOLOGY

3.1. Introduction

This chapter presents the mixed methods design employed in this study, highlighting the rationale, pragmatic paradigm standpoint and context of the acute, private inpatient hospital setting influencing the research design. A convergent mixed methods design was selected, meaning that quantitative and qualitative strands were collected and analysed separately, with convergence occurring in the discussion, where both strands are integrated and interpreted together. The quantitative strand involved statistical analysis of data collected before and after the OTIGM group intervention, which was delivered over four consecutive days with one session per day. Measures included the Mental Health Self-Efficacy Scale (MHSES), demographic information, and Likert scale rating of discharge preparedness to assess changes in self-efficacy and perceived readiness for discharge. The qualitative strand utilised directed content analysis of semi-structured interviews conducted after the OTIGM group intervention to explore participants' perceptions of how the intervention influenced the development of self-efficacy and its impact on discharge preparedness. The chapter then details the specific research methodology for both strands, including the research instruments, data collection, and analysis processes.

3.2. Research design

A convergent parallel mixed methods design was used to provide a comprehensive understanding of the relationship between self-efficacy and preparedness for discharge following Occupational Therapy Interactive Group Model (OTIGM) intervention, as illustrated in Figure 3.1. This research was based on the parallel convergent mixed methods design positioned in a pragmatic paradigm (Creswell, 2015; Morgan, 2007).

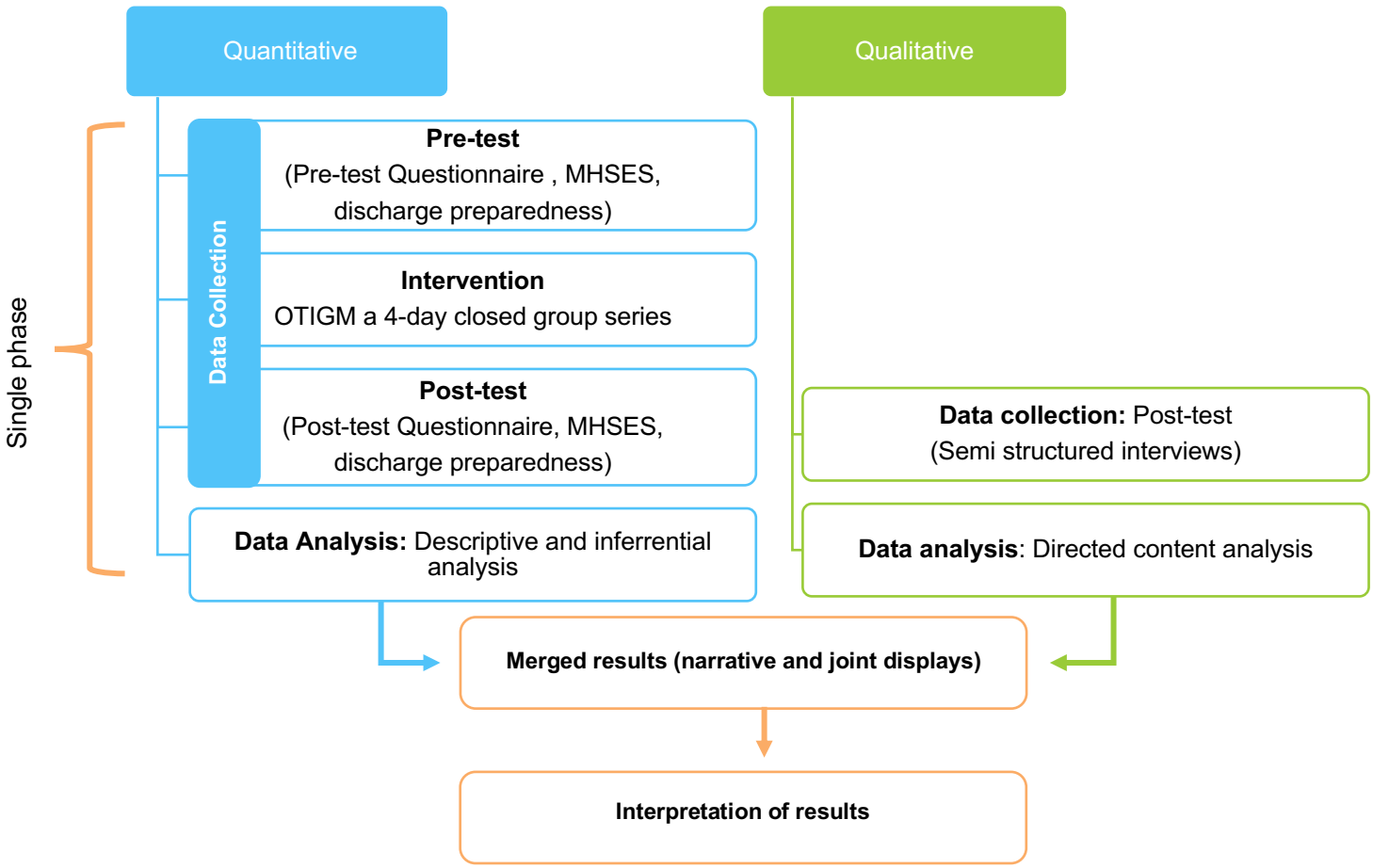


Figure 3.1 The procedure of the convergent parallel mixed methods research design used in this study.

Figure 3.1 visualises how both quantitative and qualitative strands were collected and analysed concurrently in a single-phase. Thereafter both strands were given equal priority in the merging and interpretation of the results as described by Creswell's (2015) convergent parallel mixed methods design.

The quantitative strand is a longitudinal, non-experimental quantitative study where pre-test and post-test results from the MHSES were conducted before and after MHCUs participated in the closed OTIGM group intervention over four days to reflect on objectives one, two and three. The qualitative strand consisted of a directed content analysis study using semi-structured interviews to address objective 4 to describe how the OTIGM group intervention influenced self-efficacy to impact discharged preparedness among MHCUs

diagnosed with MDD. The joint displays concluding the results and findings chapter summarise the quantitative results with qualitative findings highlighting the convergence and divergence of the two data strands. In the discussion chapter, a narrative approach to integration was used, in line with Creswell and Clark (2017). The narrative integration is presented by quantitative and qualitative findings sequentially and then compared and interpreted together. In this study the first three objectives are quantitative, the fourth qualitative objective serves to expand and explain the quantitative results across the discussion, allowing for richer interpretation. The convergent parallel mixed methods design was advantageous as it allowed for an in-depth exploration of participants' subjective experiences in the OTIGM intervention while also being efficient in terms of time and resources due to utilising the same sample criteria with different sample sizes, therefore enabling simultaneous data collection (Bradshaw *et al.*, 2017; Creswell, 2015).

3.2.1. Quantitative: Change in self-efficacy and perceived preparedness for discharge

The quantitative strand of this study was a longitudinal design of pre-test-and post-test results from the MHSES on the same sample group before and after the participants participated in the closed OTIGM group intervention that took place over four days.

3.2.2. Qualitative: Perceived influence of OTIGM intervention on self-efficacy to impact discharge preparedness

The qualitative descriptive study expands on the results of the quantitative data by using directed content analysis of semi-structured interviews as described by Leedy & Ormrod (2010) to provide a more informed understanding of how mental health self-efficacy is developed during the OTIGM intervention to impact preparedness for discharge.

3.3. Rationale for a parallel convergent mixed methods study

A parallel mixed methods design, as described by Creswell (2015), was chosen to allow for the concurrent collection and analysis of both quantitative and qualitative data within a single phase, enabling the integration of findings to provide a more comprehensive understanding of the OTIGM intervention's impact on self-efficacy and discharge preparedness. By collecting data during the same period, this design avoided the delays

associated with sequential designs. The convergent design further enabled identification of points where quantitative and qualitative data converged or diverged, enhancing interpretation by comparison with theoretical frameworks and prior research.

The quantitative strand consisted of a longitudinal pre- and post-group study using the Mental Health Self-Efficacy Scale (MHSES) and a subjective Likert scale rating of discharge preparedness. Due to the brevity of the MHSES (six items) and the single Likert scale rating for perceived readiness for discharge, the quantitative data alone was limited to fully capture the subjective and complex nature of self-efficacy. Hence, qualitative semi-structured interviews were included to expand upon and contextualise how the OTIGM facilitates self-efficacy development (Creswell & Clark, 2017). Especially since the OTIGM group intervention is practice-based based intervention which was delivered within a broader psychiatric program involving multiple concurrent therapies, which may have influenced MHSES scores. By integrating qualitative data, the design allowed for a more nuanced and isolated understanding of OTIGM's specific contribution to outcomes. Particularly in the absence of a control group due to ethical considerations of beneficence. A non-mixed approach was unsuitable because this research required the integration of outcome-based data with qualitative perspectives to provide a comprehensive, multilevel understanding of how the OTIGM uniquely contributes to the development of self-efficacy in managing mental health symptoms in preparation for discharge.

3.4. Philosophical Standpoint

This study was guided by the principles of pragmatism which enabled the researcher to develop an understanding of the relationships between self-efficacy and discharge preparedness following a closed OTIGM group intervention over a 4-day period, through the integration of theoretical frameworks and methods. The OTIGM intervention was conducted within the context of an acute psychiatric hospital programme, highlighting the need for a comprehensive approach to extract the MHCUs experience from the OTIGM intervention. The pragmatic paradigm allowed for flexibility in addressing the research question where objective measures of change and subjective data sets were used to explore the development of self-efficacy after engaging in OTIGM intervention (Creswell

& Creswell, 2018). Therefore, the use of parallel convergent mixed method including both quantitative and qualitative strands supported the pragmatic paradigm. The pragmatic worldview advocates for multiple data sets and perspectives allowing for both inductive and deductive reasoning (Johnson *et al.*, 2007; Morgan, 2007).

This study investigated the intersection of theoretical frameworks of Fouché's (2021), OTGIM, Bandura's (1977) Social Learning Theory on self-efficacy, and discharge preparedness in the context of occupational therapy seminal work such as Wilcock (1999) and Kielhofner and Forsyth (1997). Figure 3.2 serves as visual representation of the integration between the theoretical frameworks showing the development towards discharge preparedness.

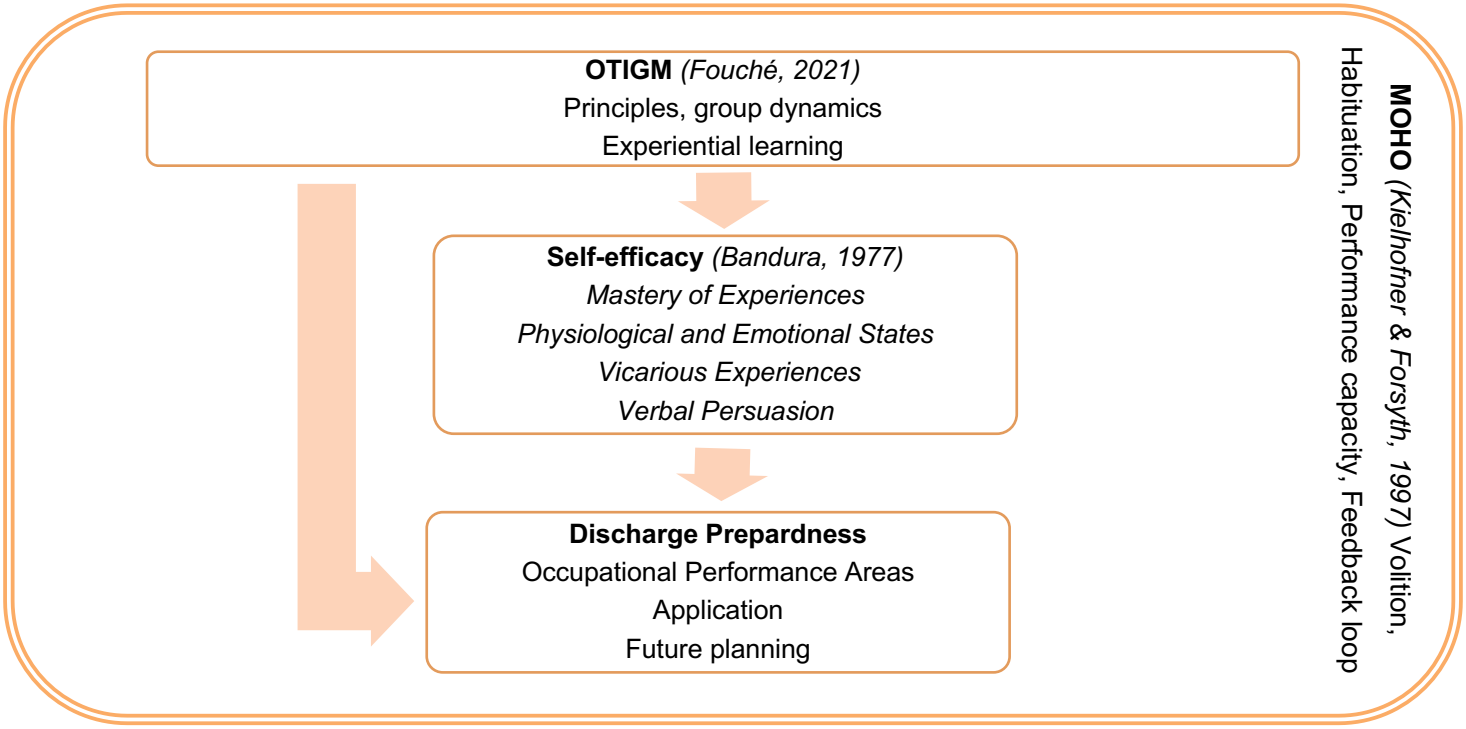


Figure 3.2: Theoretical Integration of MOHO (Kielhofner & Forsyth, 1997), Bandura's Self-Efficacy (Bandura, 1977), and OTIGM (Fouché, 2021)

Figure 3.2 is bounded by a double rectangle, signifying MOHO as the overarching occupational lens that frames the entire process. The MOHO emphasises the role within a dynamic feedback loop which incorporates external experiences to shift internal system (volition, habituation, and performance capacity) to reinforce positive change (Kielhofner & Forsyth, 1997). Meanwhile, OTIGM (Fouché, 2021) shapes the group environment, where therapeutic group dynamics and experiential learning occur. Fostering Bandura's (1977) four sources of self-efficacy (mastery of experiences, physiological and affective states, vicarious learning and verbal persuasion). Inside of the double lined rectangle in Figure 3.2, a flow diagram uses arrows to show the potential relationships where the OTIGM intervention influences self-efficacy, and that both self-efficacy and OTIGM contribute to discharge preparedness. Pragmatism focuses on real-world application, problem-solving, and flexibility which allows for the application of the above-mentioned occupational therapy theories to improve the daily functioning impaired by symptoms of MDD. The inclusion of discharge preparedness extends the application of OTIGM beyond the acute psychiatric setting, reinforcing the practical implications of self-efficacy. Furthermore, the OTIGM promotes client-centred activities, allowing MHCUs to engage in meaningful, goal-oriented tasks based on their worldviews and lived experiences.

3.4.1. Ontological assumptions

The reality of one's beliefs is subjective and therefore an open-minded approach to pluralism was essential in capturing the diverse experiences of MHCUs across different OTIGM groups. Since self-efficacy is a multifaceted, subjective construct, it was effectively studied using both measurable scales and personal experiences (Bandura, 2006). This aligned with occupational therapy literature which emphasises a holistic understanding of MHCUs within their broader environment, considering their personal motivators, values, roles, and capacities (Taylor *et al.*, 2023). Critical realism was applied through the integration of mixed methods, allowing for an in-depth exploration of both convergence and divergence in the results (Cuthbertson *et al.*, 2020).

3.4.2. Epistemological assumptions

This study acknowledged the perspectives of the MHCUs prior to discharge from an acute psychiatric hospital, recognising the value of their lived experiences in understanding the impact of OTIGM. A pragmatic approach employed practicality to extract insights into how OTIGM influences MDD symptoms within the context of a full psychiatric hospital program, especially in the absence of a control group (Creswell & Clark, 2017). Given that the researcher is embedded within the data collection site, a comprehensive, contextually grounded understanding of the research environment was achieved. This study adopted a constructionist perspective, recognising that knowledge is co-constructed through integrating objective measures and participants' experiences. By examining the relationship between self-efficacy and discharge preparedness through both qualitative and quantitative data strands, the study bridges subjective and objective knowledge. Furthermore, the action-based nature of pragmatism aligns with occupational therapy theory, which emphasised the role of 'doing' as a means to facilitate positive change in functioning (Creswell & Creswell, 2018; Wilcock, 1998).

3.4.3. Axiological assumptions

The axiological assumptions made in this study highlight multiple stances to reflect on both biased and unbiased perspectives when collecting subjective data (Creswell & Clark, 2017). Given the pragmatic paradigm, a mindful approach was taken to balance deductive analysis with openness to emerging insights, ensuring that findings were not overly constrained by pre-existing frameworks.

3.4.4. Methodological Assumptions

The mixed method approach integrates both qualitative and quantitative strands to provide a comprehensive understanding of self-efficacy development. The quantitative strand assesses pre- and post- OTIGM intervention of change of discharge preparedness rating and the MHSE using the MHSES as well as the relationship between these variables. The qualitative strand consisted of semi-structured interviews focusing on open ended questions directed by Fouché's (2021) OTGIM and Bandura's (1977) Social Learning Theory on self-efficacy. This approach allowed for an in-depth reflection on how

OTIGM influenced Mental Health Care Users (MHCUs) with MDD. The findings were interpreted within the acute psychiatric hospital and the context of MDD offering insights into how OTIGM shaped both self-efficacy and discharge preparedness. By combining both methodological strands, the study provides a richer, more nuanced understanding of the OTIGM.

3.5. Research context

The OTIGM intervention is currently being implemented by the private occupational therapy practice at a voluntary, acute, inpatient, private psychiatric hospital in South Africa. The intervention is structured in a closed group format and delivered over four consecutive days, with each session lasting approximately 1 hour and 45 minutes. MHCUs are admitted under the guidance of a psychiatrist who is the MHCU's case manager referring for appropriate therapies at the hospital, including OTIGM groups. The hospital promotes a therapeutic daily milieu conducive to the promotion of mental health in order to prevent institutionalisation, a weekly group to reflect on the tools gained to develop a re-integration plan for after discharge, and the hospital website has a blog with advice for post-discharge. On average medical aids cover for a standard 21 days of in-hospital prescribed minimum benefits (Meyer, 2020). The researcher has four years of experience in OTIGM intervention, has received in-service training and has attended courses provided by OT Grow which is an organisation that trains facilitators in the OTIGM (OT Grow, 2022).

3.6. Population

The study population consisted of MHCUs admitted to an acute, voluntary, private inpatient psychiatric hospital in Gauteng, South Africa. The sample population included English-speaking males and females over 18 years old, diagnosed with MDD, including both first-time admissions and readmissions. Participants were referred to the OTIGM group intervention by their treating psychologists or psychiatrists based on the hospital's standard clinical referral process and group suitability.

3.7. Quantitative strand: Change in self-efficacy and perceived preparedness for discharge

3.7.1. Measuring instruments

3.7.1.1. Pre- and Post-test Questionnaire

Both the pre-test and post-test questionnaire was developed from the literature by the researcher for this study. The demographic questions were modelled from the demographic information obtained in the study by Ngooi *et al.*, (2022). The pre-test demographics questionnaire (APPENDIX B) determined the participant's general demographic information, mood rating and discharge preparedness. The options for the mood scale included "depressed, sad, neutral, content, happy". A 10-point Likert scale addressed readiness for discharge prompting: "Do you feel ready for discharge?" ranging from 1 "Not at all confident" to 10 "Totally confident". The post-test questionnaire (APPENDIX C) followed up on mood and discharge readiness and determines what other therapies the participant engaged the closed OTIGM group intervention over four days.

3.7.1.2. The Mental Health Self-Efficacy scale

The MHSES developed by Clarke *et al.* (2014), based on Bandura's (2006) guide for constructing self-efficacy scales, was used to collect the data (Appendix A). The MHSES was developed by Clarke *et al.* (2014) to specifically quantify an MHCUs ability to cope with symptoms of stress, anxiety, and depression. As Bandura (2006) developed a 'Guide for Constructing Self-efficacy Scales' for other researchers to build self-report questionnaires to fit within a specific domain of functioning. Clarke *et al.* (2014) used the MHSES in a study to determine the efficacy of a web-based psychotherapy intervention among online-recruited individuals reporting symptoms of depression, anxiety, and stress. The MHSES has demonstrated unidimensional validity, with strong internal reliability (Cronbach's alpha = 0.89) and well-established construct validity (Clarke *et al.*, 2014). The MHSES is based on the question, "*How confident are you on an average day in the next month you will be able to….?*" Which is completed with six questions addressing ability to manage stress, anxiety, or depression. The questions are self-administered by the participants and answered on a 10-point Likert scale ranging from 1 "*Not at all confiden*t"

to 10 "*Totally confident"* and then totalled by the researcher when capturing results (Clarke *et al.*, 2014).

3.7.2.Pilot for the Pre- and Post-test Questionnaire Administration

The quantitative pilot study aimed to determine the clarity of the questions and administration of the measuring instruments, areas of ambiguity, to refine the process of recruiting participants, and to become familiar capturing data on REDCap (which is a web-based application developed by Vanderbilt University used for collecting and managing research data) (Patridge & Bardyn, 2018). Participants completed paper-based questionnaires which were then captured electronically by the researcher onto REDCap. The participants for the pilot group of the quantitative measuring instrument were sampled from the researcher's own OTIGM group. Allowing for critical feedback about the questions, as the participants had developed a relationship with the researcher during the group process. After collecting the data for the pilot study and reviewing the results, some minor changes were made to the questionnaire, such as adding a question of whether they attended Electroconvulsive Therapy (ECT) for the exclusion criteria, removing a witness signature from the consent form as group members attending the OTIGM groups are clinically fit to provide informed consent. The most significant change was adding a question to the REDCap data capturing questionnaire to confirm the MHCU's ICD-10 diagnosis on the hospital system, rather than using the MHCUs' perceived diagnosis. Some pilot participants were not aware of their diagnosis. An amendment was made in accordance with ICD-10 on the participant consent sheet (APPENDIX J) informing MHCUs that their medical information from the hospital was reviewed in alignment with Protection of Personal Information Act (South Africa, 2013).

The pilot study also allowed the researcher to get feedback on the questionnaire administration, the requirement process and to determine any changes that needed to occur in the data collection process and/or data management plan. Only four out of eight group members volunteered to participate. However, only three attended the information session, reflecting the poor efficacy of the invitation to an information session. Thus, it

was resolved that information sessions would take place 15-30 minutes before the start time of the OTIGM.

3.7.3. Sampling

Non-probability purposive sampling was used to recruit mental health care users (MHCUs) who had completed all four sessions of the OTIGM group intervention. Participants were selected from those already referred to the OTIGM group by their treating psychiatrist or psychologist as part of the hospital's standard therapeutic programme. These clinical referrals were made independently of the research, based on the professional judgement of the treating clinicians.

For inclusion in the study, participants had to be over 18 years of age, have a primary diagnosis of Major Depressive Disorder (MDD)—either acute or chronic—and be able to communicate in English. Only those who completed all four sessions of the OTIGM group intervention were eligible. Exclusion criteria included individuals experiencing acute psychotic symptoms, those currently undergoing Electroconvulsive Therapy (ECT), and any MHCUs who were part of a group facilitated by the researcher, to minimise the risk of bias in data collection.

The psychiatric hospital where the research was based has 150 inpatient beds. As part of the hospital's routine therapeutic programme, between 32 and 48 MHCUs (approximately 21% to 32% of total inpatients) are referred weekly to attend OTIGM-based socioemotional groups. Referral data is routinely recorded for the overall group programme however formal statistics specifically documenting the number of MHCUs with a diagnosis of MDD who complete the OTIGM groups are not maintained. Given that 65% of hospital admissions are typically diagnosed with MDD, this proportion was applied to estimate the number of potential participants eligible for inclusion in the study. Therefore, the population size is estimated at approximately 97.5 individuals. Based on the confidence interval (95%), margin of error (5%), population size (97,5) and proportions (21%-32%), a sample size of 71-76 participants was confirmed for this study in consultation with a statistician.

3.7.4. Recruitment process

The occupational therapists who facilitate the OTIGM groups were recruited to assist in the data collection process (APPENDIX L) and nursing staff informed to assist with requirement (APPENDIX M). Participation in the research was voluntary, and MHCUs were invited to opt-in to complete the questionnaire before and after attending the OTIGM group as part of their hospital programme as referred by their psychiatrist or psychologist. MHCUs who opted not to participate in the study still attended the group as they were referred for the group intervention. Used the approved information sheet to explain the research and the nature of their involvement and so that those who agreed to participate signed the consent form. The OTIGM intervention groups typically begin on a Monday, on the preceding Friday, MHCUs referred by their psychiatrists or psychologist are notified of their allocation to the OTIGM group through letters, which are distributed to the wards by ward staff and nursing staff. Attached to these referral letters was an invitation, inviting MHCUs to meet 15 minutes prior to the start of their group (APPENDIX E).

3.7.5. Data collection

Eligible MHCUs were briefed and given the information sheet (APPENDIX D) before the start of the first session and were made aware of their rights within research, as discussed in the ethics section below. Thereafter, the consenting MHCUs completed the paper-based pre-test questionnaire (APPENDIX B) and the MHSES (APPENDIX A). The hard copies of the pre-test questionnaires were then captured on REDCap.

3.7.6. Data Analysis

The data on REDCap were cleaned and finalised and then exported to an Excel spreadsheet where the data were sorted. The data was analysed using IBM SPSS version 29.0.2.0 (20) and Stata/SE 18.0. Descriptive statistics were used to analyse the demographic information of the sample. The comparative study by (Clarke *et al.*, 2014) similarly calculated the sum of the ratings across the six MHSES items for each participant (scores range from 0 to 60) to obtain an overall measure of their mental health self-efficacy, with higher scores indicating greater self-efficacy. Therefore, the total scores of the MHSES are treated as interval data.

To address Objective 1, the change in MHSES and discharge preparedness scores from pre- to post-intervention was calculated by subtracting pre-test scores from post-test scores. The normality of these change scores was assessed using the Shapiro-Wilk test. Where normality was satisfied, a paired t-test was applied; where not, the Wilcoxon signed-rank test was used. For Objective 2, the influence of demographic factors (age, gender, race, education level, marital status, employment status, previous admission, presenting mood, and number of days admitted prior to the group) on the change in MHSES and discharge preparedness scores was first examined using Spearman's rank correlation. Demographic variables that showed potential associations, based on Cohen's benchmarks for effect size, were then entered into a linear regression model to determine their predictive value. To address Objective 3, Spearman's rank correlation was again used to assess the relationship between the change in MHSES scores and change in discharge preparedness scores; exploring whether increased self-efficacy was associated with greater perceived readiness for discharge.

3.8. Qualitative Strand: Perceived influence of the OTIGM intervention on self-efficacy to impact discharged preparedness

3.8.1. Development of the interview guide

The interview guide used the literature on the elements of the OTIGM, self-efficacy, discharge preparedness and the use of questions in the MHSES (Bandura, 1977; Clarke *et al.*, 2014; Fouché, 2021). The researcher drew inspiration from the interview questions from Ramano, (2017) which is based on focus group discussions held at the end of an occupational therapy activity-based group therapy programme for inpatients with major depressive disorder. The fourth objective guided the topics of the interview, including the participants' perceived experience of the intervention, activities used, confidence in dealing with symptoms of MDD, and feeling towards discharge. Gillham (2000) proposed the inclusion of open-ended questions to encourage participants to provide authentic subjective experiences, where questions started broadly and gradually became more specific, allowing participants to ease into the conversation before tackling complex issues with probing question. APPENDIX F: Interview guide for qualitative data, shows the final interview guide was developed after the pilot as described in the section below.

3.8.2. Post-test Questionnaire

The demographic information was collected using the same instruments and process as quantitative strand. Since the interview was completed after the group only the Post-test questionnaire was used.

3.8.3. Face validity of interview questions and Pilot Study

Guest *et al.*, (2006) suggested a pilot study to pre-test the interview guide and determine whether questions were relevant and enabled the collection of rich data to address objective 4. Before the pilot study of the qualitative data collection, two preparation interviews were conducted to explore the efficacy of the interview guide that had been developed:

1. A colleague who presents OTIGM groups: Adaptions were made to the protocol interview as questions were noted to be too closed and narrow as there was significant repetition in answers and missing key questions focusing on 'how' prompts. To make these corrections focused on shifting to broader, less leading questions, and to break down the different aspects of the OTIGM (group environment, therapist's facilitation techniques, activities experienced etc.) to gain deeper data.
2. A lay person who has not experienced the group process: shifted questions to reduce bias, simplifying open ended questions, and identified occupational therapy Jargon. It also assisted with ensuring a flow of questions.

The researcher used, 'the pilot interview guide' (Guest *et al.*, 2006) to conduct the pilot study with single individual who mirrored the target population The pilot participant was from the researcher's group allowing for effective feedback on questions due to pre-established relationship. The pilot interview was done eight days after the pilot participant completed the OTIGM intervention due to appointment constraints. The pilot interview was recorded and was analysed with research supervisors. Feedback was provided on questioning style, use of prompts and/or refocus on questions, and to evaluate whether data obtained aligned with objective 4. Ensuring an informed questioning guide for the final interview guide (APPENDIX F).

3.8.4. Sampling

Systematic and sequential purposive sampling was employed until data saturation was reached (De Vos *et al.*, 2011). The inclusion and exclusion criteria mirrored those of the quantitative strand; however, qualitative participants were not explicitly drawn from the same sample. MHCUs who had completed the OTIGM group intervention as part of their therapeutic programme were invited to volunteer for individual interviews. To promote sample diversity and limit potential selection bias, group facilitators provided suggestions for potential participants based on age, race, gender, admission history, and perceived engagement or benefit from the group. Facilitators had insight into all group members and not just those who were likely to volunteer, therefore their input helped to ensure a more varied and representative sample. Therefore, increasing the likelihood of including a broader range of perspectives and experiences, enhancing the depth and credibility of the findings. Potential participants were then screened to ensure they met the inclusion and exclusion criteria. Thirteen interviews were conducted ranging from 30 and 50 minutes in length. Content saturation was noted during data collection when additional interviews were no longer yielding new information and concepts were becoming redundant in participants reflection.

3.8.5. Recruitment Process

Once participants were identified through purposive sampling and their eligibility confirmed by the researcher, they were scheduled for interviews 0–2 days after completing the OTIGM intervention. Informed consent for participation and audio recording was obtained at the start of each interview (APPENDIX K).

3.8.6. Directed Content Analysis

A directed content analysis using deductive coding based on Bandura's (1977) Social Learning Theory was applied to systematically analyse the transcribed interviews, following Hsieh and Shannon's (2005) approach. The main goal of this approach is to support and expand on existing theory of the OTIGM, self-efficacy and discharge preparedness. Thus, the analysis used deductive coding however inductive coding was

also used to identify key concepts, variables and links. The analysis process comprises of six steps which are outlined in Figure 3.3.

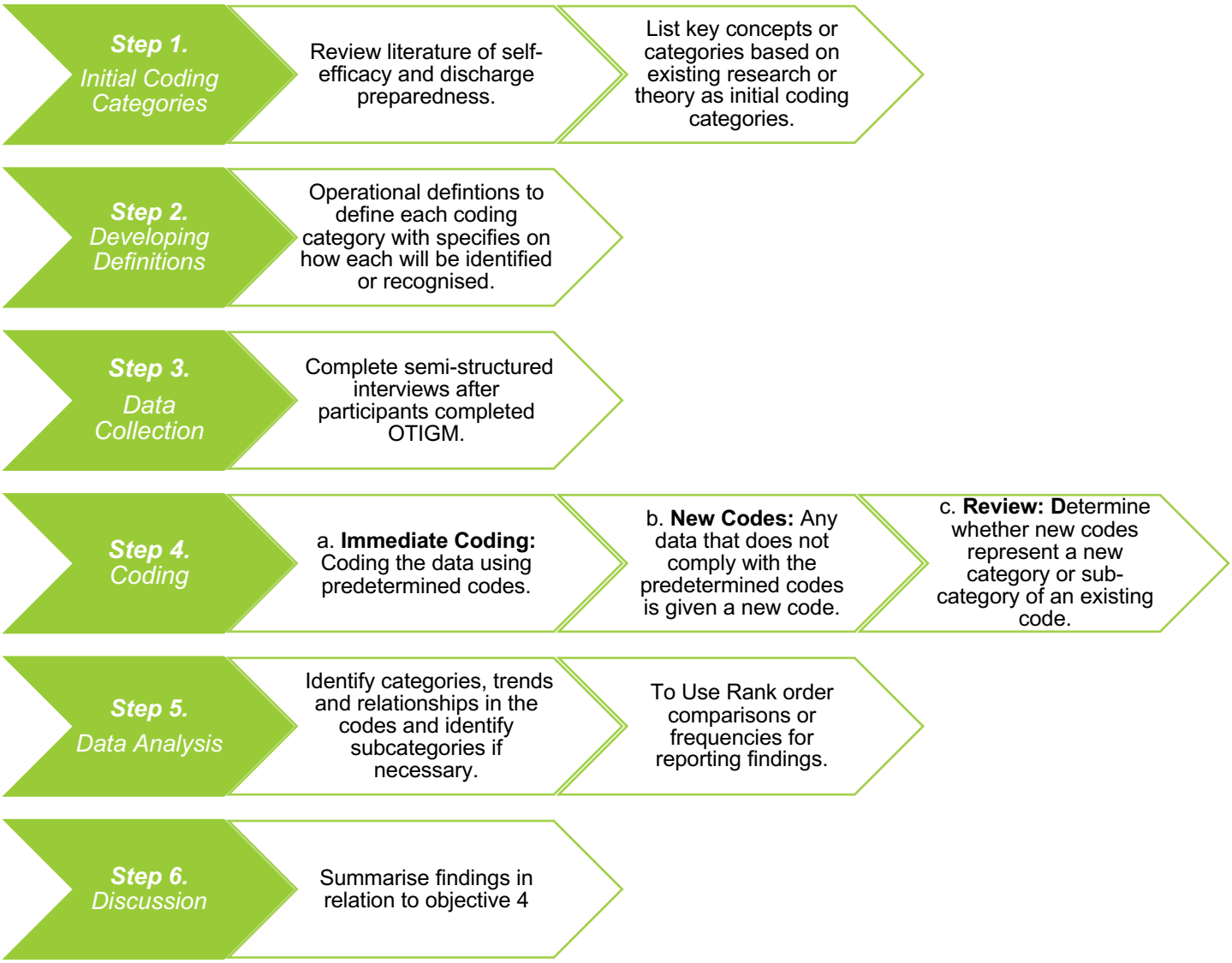


Figure 3.3 The steps of the directed content analysis method applied to research objective 4 to explore the perceived impact of the OTIGM intervention on self-efficacy to impact discharge preparedness among MHCUs diagnosed with MDD.

Figure 3.3 depicts the data analysis process of qualitative data. Steps one and two were done prior to data collection where initial coding categories and developing operational definitions (APPENDIX N) identified the four sources of self-efficacy, important OTIGM principles and components of discharge preparedness identified from the literature. Adjustments were made to predetermined codes, increased scope 'relapse' and 'Areas of occupation' discharge preparedness phenomena; some codes in OTIGM theme were collapsed due to repetition and overlapping. After, the initial coding of the first interview was conducted it was peer-reviewed to increase validity. A total of 43 possible codes were generated from the literature of these three themes.

In step 3, the qualitative data was then collected by the researcher through semi-structured interviews to determine how the OTIGM influenced self-efficacy and preparedness for discharge. During the semi-structured interviews, the researcher created a comfortable environment to reduce anxiety, allowing participants to share their experiences of the OTIGM in a non-threatening, conversational setting. Participants were informed about the duration of the interview to allocate appropriate time when setting an appointment on their timetables. The participants completed a consent form prior to staring and privacy had been taken into consideration when selecting venues for the interviews. The interviews were recorded on two devices using Voice Memos Version 2.4 (1158) application. Thereafter, recorded interviews were uploaded to the researcher's OneDrive immediately to ensure safety of data; further information is explained in data management plan (APPENDIX I). The interviews were in English and were approximately 30-50 minutes in duration which allowed for a comprehensive understanding of the participants experience of the OTIGM group intervention. A total of thirteen interviews were conducted and on revision of inclusion and exclusion criteria, three were discarded due to diagnosis of bipolar depressive episodes that only became apparent during the interviews process. The ten selected audio recordings were transcribed automatically using the AI editing software tool Descript, which transcribed the data into a word document, the transcribed data were then reviewed and corrected by the researcher to ensure that accurate, verbatim transcripts were produced. The transcripts were uploaded to MAXQDA 2022 (VERBI Software, 2021), which is a software program used for

qualitative data analysis to code, categorise and assist in generating visual representations of the data. Resulting in the opportunity for immersion to promote sufficient gauge and familiarity with the data prior to coding and to ensure trustworthiness (which is discussed further in the section 3.10). In step 4a and b, deductive coding used the predetermined codes as a guideline and inductive coding coded data that did not conform to the predetermined codes and new categories were produced.

Thereafter, in step 4c, the predetermined code categories, sub-codes and inductive codes were reviewed. Reviewing codes involved a manual process of comparing the 43 predetermined codes with the actual codes produced. A total of 229 raw codes were found with 1050 occurrences. The themes and categories were refined to allow for a concise interpretation of the data through peer review and analysed. Evidence of the analysis process in step 5 can be seen in APPENDIX O where categories for themes were identified. An inductive category of 'self-agency' within the OTIGM theme was found and integrated predetermined codes of 'encourage independence' and 'confrontation' Two additional codes, 'Duality' and 'Synergy of the therapeutic programme', were identified that did not fit into any of the themes and instead were incorporated as areas of interest. Depth was added to each category by assigning additional codes that were not included in the predetermined categories. For additional clarity, subcodes were identified, for example, 'Application' code could be sub-coded as 'Application in hospital' or 'Apply it going forward' allowing for nuances of codes to be evident. Some codes were reclassified or merged for example, a segment coded as 'improved mood' was recoded as it was better classified as 'change'; and the 'affirmations' code was merged with 'motivational encouragement'. Finally, step 6 summarises the findings to address objective 4 which explored the perceived impact of the OTIGM intervention on self-efficacy to impact discharge preparedness

A final total of 196 codes were identified: producing 1058 segments. Relevant and meaningful data was selected with careful consideration, ensuring that valuable segments were included. The reviewed and final codes are noted in the mind map produced within MAXQDA software called Maximaps reflects the categories of each theme with

corresponding codes (APPENDIX P). The final codebook (APPENDIX Q) displays the greater details of the sub-codes reflecting the nuances of the codes allowing for identification of supportive and non-supportive evidence of the research objective to ensure a critical view of the findings. Appropriate quotes were selected from coded segments to describe the patterns and relationships within and between the codes. Codes were analysed to deepen the insights and outcomes of the findings to support, refine and extend on the existing theory and/or literature. The codes were initially explored in the analysis process and further explored in the write up of each theme.

3.9. Data management

A detailed outline of the data management process has been outlined in APPENDIX I . The hard copies of the quantitative data collected from the MHSES (APPENDIX A), and the pre-test demographic questionnaires (APPENDIX B) were securely stored in files and kept at the University of the Witwatersrand. Participants used their patient identifier codes at the hospital to link their pre- and post-test scores. For confidentiality, patient identifier codes were replaced with new identifiers when the data was captured on REDCap system. Audio recordings of interviews were transcribed verbatim with the assistance of Descript, Version 96.0.2, transcription software. Pseudonyms were used in the transcription of the qualitative data which were used in the results and discussion sections of this dissertation. Both the quantitative and qualitative raw data were organised, refined and password protected on a hard drive. This data is only accessible to the researcher and the supervisors.

3.10. Trustworthiness and Rigor

This section describes those various parameters to ensure validity and reliability of the quantitative stand and trustworthiness of qualitative stand.

Internal reliability of the quantitative data tool, MHSES, proved to be acceptable with a Cronbach’s alpha 0.89 and evidence for construct validity. Rigour of the results was also ensured by cross-checking the MHCUs main diagnosis with the hospital information as it

was noted during data collection. Furthermore, a biostatistician was consulted who guided and assisted with the statistical analysis.

A directed content analysis based on Bandura's (1977) Social Learning Theory guided the coding process. However, to reduce the risk of limiting the findings by not hyper-focused on the theoretical basis the researcher remained open to new insights(Krefting, 1991). To ensure credibility, the qualitative data were peer-reviewed by the research supervisors during both the pilot and analysis phases, particularly regarding the use of predetermined codes, development of categories, and final themes. Credibility and bracketing were strengthened by using neutral prompting questions, asking participants to clarify responses, and avoiding interpretive bias during coding by focusing on participants' responses rather than inferred meaning. Dependability was insured by having the same researcher conduct all interviews so that the mode of asking questions remained consistent in the collection and analysis of the data (Korstjens & Moser, 2018). Positionality was acknowledged that the researcher is an employee at the study site and is a facilitator of the OTIGM groups being studied, as this has an impact on the objectivity of the data analysis (Flick, 2018). Therefore, reflexivity was supported by the researcher not facilitating any of the OTIGM groups involved in the study, which helped to reduce the personal influence on participant selection or responses. Transferability was supported through a clear description of the research context of an acute private psychiatric hospital, involving adults diagnosed with MDD. Confirmability was ensured through an audit trail: Appendix N shows the operational definitions, Appendix O outlines initial coding phases, Appendix P presents final categories, and Appendix Q details the final codes. The final findings were also peer-reviewed by researchers to enhance trustworthiness.

3.11. Ethical considerations

Ethical clearance was obtained from the Human Research Ethics Committee (HREC) at the Faculty of Health Sciences at the University of the Witwatersrand (M240108 M240417-A-0001), to ensure that the study complies with the ethical standards to protect the rights of participants. Permission from the occupational therapy practice and the hospital was obtained (APPENDIX H). This study ensured non-maleficence by not incurring harm to

the patients as they are engaging in the general milieu of the hospital program with additional assessment of their experiences to promote OTIGM to assist greater populations and promote beneficence through providing further evidence of practice. Through autonomy participants were able to voluntarily to elect to participate in the study after informed consent was gained (Thomas, 2013) by providing an information sheet (APPENDIX D). Participants were selected through objective non-probability, systematic and sequential purposive sampling. The researcher was not a treating facilitator in the OTIGM groups that were included in the study to guarantee justice. Furthermore, participants were allowed to withdraw from the study at any time without repercussions (Kruger *et al.*, 2014). The distress protocol included in this study is defined as 'low risk' according to the Medical Human Ethics Research Committee (HERC), due to the low risk of psychological distress during the qualitative interview where the "only foreseeable risks is that of temporary discomfort, or where there may be some sensitivity involved in terms of the questions asked" (APPENDIX G). The distress protocol was not needed. Confidentiality was ensured through the use of REDCap and qualitative capturing software to capture and store data was used in compliance with the POPI Act as described in the data management plan (APPENDIX I). The anonymity of the MHCUs was ensured by using codes for semi-structured interviews and de-identifying quantitative data when it is analysed. Participants were given consent for audio recordings as outlined in APPENDIX H. The data collected in this study was only used for the purposes of this research outlined in the 'Dissemination and Translation' section above.

3.12. Conclusion

A parallel convergent mixed methods research approach, quantitative and qualitative, was used to enable the researcher to describe how the 4-day OTIGM intervention promotes self-efficacy and discharge preparedness. Evidence of change in participants with MDD was displayed through pre- and post-test MHSES scores after engaging in the intervention. Qualitative interviews were used to explain how the principles of the OTIGM facilitate self-efficacy and promote participants to be more prepared for discharge. The next chapter separately presents the results for the quantitative and qualitative strands, based on the data analysis methodology outlined in this chapter.

CHAPTER 4: RESULTS AND FINDINGS

4.1. Introduction

This chapter serves to present, illustrate and describe the results and findings from the data collected to address the objectives of this study. As per the methodology of a parallel convergent mixed methods study, the results displaying the quantitative and findings of the qualitative strands separately. The quantitative strand includes objectives one, two and three reflecting on self-efficacy and discharge preparedness variables. The qualitative strand addressed objective four highlighting the perceived impact of the Occupational Therapy Interactive Group Model (OTIGM) intervention on self-efficacy and discharge preparedness.

4.2. Quantitative Strand: Change in self-efficacy and perceived preparedness for discharge

4.2.1. Introduction

The quantitative strand involved a longitudinal design, analysing ordinal data collected from Likert-scale responses using descriptive statistics to address objectives. The first objective determined the effect of the OTIGM intervention on mental health self-efficacy (MHSE) and discharge preparedness. The second determined the effect demographic factors on self-efficacy and the third objective established the relationship between MHSE and discharge preparedness in participants diagnosed with Major Depressive Disorder (MDD). The dependent variables are the MHSES scores and discharge preparedness ratings, while the independent variable is the OTIGM intervention. To assess changes in self-efficacy and discharge preparedness before and after the OTIGM intervention, paired sample t-tests, Wilcoxon signed-rank tests, and one-way ANOVA were conducted. Additionally, linear regression analysis was used to explore the potential demographic predictors of change. The results are presented through descriptive, parametric and non-parametric inferential statistics. The statistical analysis was generated with the consultation and assistance of a biostatistician.

Over a seven-week period (6 May to 21 June 2024); a total of 112 questionnaires were submitted 25 were incomplete, 9 were deemed invalid (double answers, did not complete the pre- or post -test questionnaire) and 3 were excluded due to not having a main diagnosis of MDD. Accordingly, 78 questionnaires fulfilled all inclusion criteria and were included in the final analysis, thereby meeting the calculated sample size requirement of 71 to 76 participants.

4.2.2. Demographics of the sample

The demographic information of the 78 participants is presented in Table 4.1. The ages of the participants ranged from 18 to 58 (mean = 36). The majority of the sample were employed, black females with higher education degrees who were not married. The median number of days admitted prior starting the OTIGM intervention was eight days, and 69% were experiencing their index admission.

Table 4.1 Demographic information of the quantitative sample (n=78)

Variables	***Number (%)***	***Mean (SD)***	***Median (Q_1-Q_3)***
Age (Years)	.	36 (10)	.
Gender Number *Female* *Male*	 61 (78) 17 (22)	.	.
Race *Black* *White* *Coloured*	 69 (88) 8 (12) 1 (1)	.	.
Education *High school* *Undergraduate* *Post-graduate* *Other**	 17 (22) 26 (33) 24 (31) 11 (14)	.	.
Marital Status *Single* *Married* *Divorced* *Widowed* *Other***	 42 (54) 24 (31) 6 (8) 3 (4) 3 (4)	.	.
Employment	61 (78)		

Employed full time *Employed part time* *Unemployed* *Studying* *Other****	3 (4) 3 (4) 7 (9) 4 (5)	.	.
Previous Admissions *No* *Yes*	54 (69) 24 (31)	.	.
Number of Days admitted prior to starting the group	.	.	8 (6-10)

**Other in Education includes Diploma, college certificate, NQF levels ** Other in Marital status includes separated, living together but not married ***Other in Employment self-employed, incapacity*

4.2.3. Objective 1

To determine the change in self-efficacy, using the MHSES, and the change in discharge preparedness in MHCUs with MDD after participating in the OTIGM intervention.

Of the 78 participants, 14 (18%), recorded a decrease in MHSES scores between the pre and post group scores, 7 (9%) noted no change while most, 57 (73%) participants scores improved. The data analysis below expresses data to determine the effect of the change in MHSES scores after a MHCU with MDD attended the OTIGM intervention. Both the median and the mean from the pre-test (36, 36.03) increased to the post-test (47, 44.60) as displayed in the box plot in Figure 4.1.

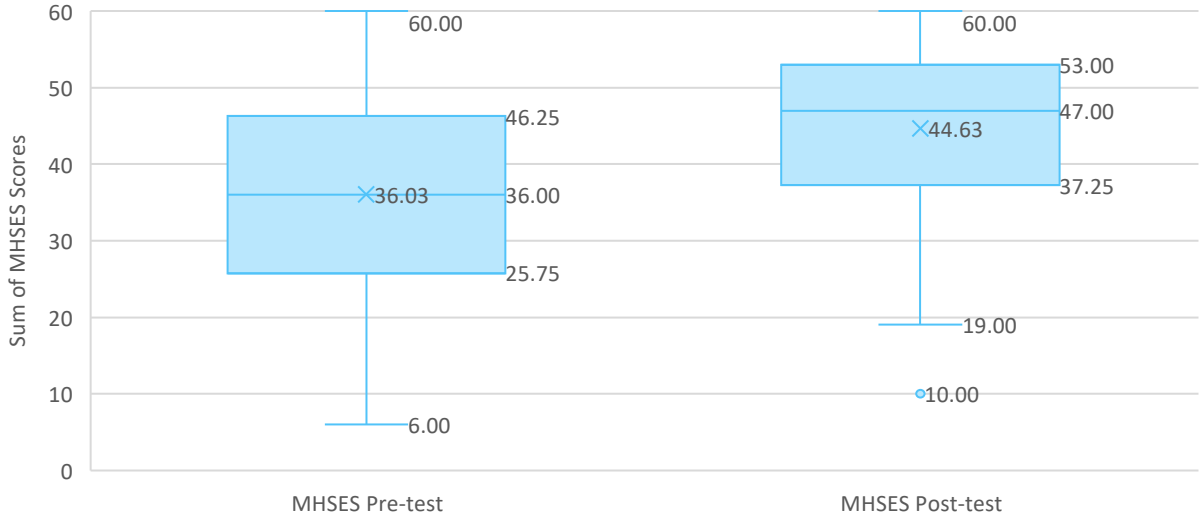


Figure 4.1 Change in the scores of the Mental Health Self-Efficacy Scale

It was found that the change in MHSES scores (MHSES after – MHSES before) satisfied normality using Shapiro-Wilk (p-value = 0.134), thus performing a paired t-test test which presented with a mean difference of 8.60 (10.036), p-value < 0.001 at a 95% confidence interval. Reflecting a statistically significant change in MHSES after participating in OTIGM. The outlier in Figure 4.1 was noted in the MHSES post-test scores and is discussed further in Table 4.2. on page. 50.

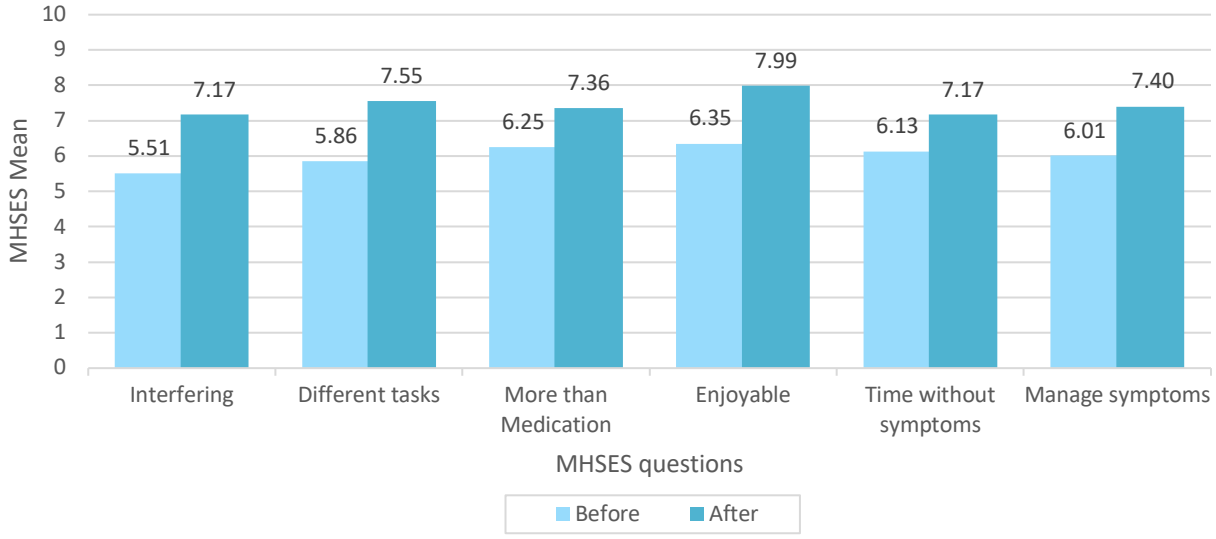


Figure 4.2 Change of the Mental Health Self-Efficacy Scale responses of each question before and after Occupational therapy interactive group mode intervention

Figure 4.2 indicates the individual questions on the MHSES (APPENDIX A). The MHSES components were not normally distributed, and the differences of pre- and post-test results were non-symmetrical therefore applied a Wilcoxon Sign Test as a non-parametric alternative to a paired-sample t-test to determine if each variable of the MHSES is significant. The Wilcoxon Sign Test revealed that the changes in variables of MHSES scores from pre- to post-test were significant (p-value < 0.001) for all the questions of the MHSES, except for 'more than medication' (p-value = 0.001). Thus, there was a positive change in MHSES scores for all the questions with 'enjoyable' having the highest mean difference of 1.69 and 'time without symptoms' had the mean difference of 1.04.

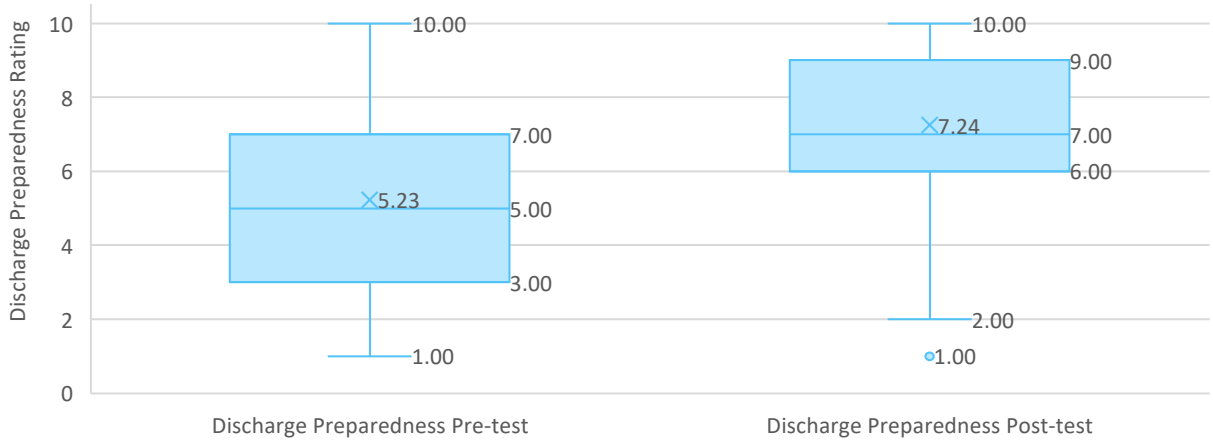


Figure 4.3 Change in the rating of discharge preparedness

Figure 4.3 depicts the change in discharge preparedness before and after the OTIGM intervention. The median of discharge preparedness was indicated to increase from pre-test (5.00, 3.00-7.00) to post-test (7.00, 6.00-9.00). Normality testing using the Shapiro-Wilk test (p-value < 0.001) does not meet the assumptions for paired sample t-test, therefore using the non-parametric equivalent Wilcoxon Signed-Rank test which revealed a statistically significant difference in discharge preparedness ratings presented with a mean difference of 2.01 (0.56) (p-value < 0.001). Therefore, rejecting the null hypothesis, which predicted no change in MHSES scores and discharge preparedness ratings after the OTIGM intervention.

4.2.4. Objective 2

To determine the effect of demographic factors on the change in self-efficacy and the change in discharge preparedness in MHCUs diagnosed with MDD following OTIGM.

Table 4.2 displays the effect of demographics on change in MHSES scores (MHSES post-test – MHSES pre-test). Categories such as race, employment and marital status from the demographics were collapsed into fewer categories due to low variety to allow for analysis.

Table 4.2 The effect of variables on the change in Mental Health Self-Efficacy scale scores

Variables	Correlation	Mean (SD)	Median (Q_1-Q_3)	P-value
Age (years))corelation			.	
With outlier	-0.26	.		*0.023
Without outlier	-0.21			0.070
Gender (Mean)				
Female	.	9.4 (11.8)	.	0.229
Male		5.8 (6.9)		
Race				
Black/Coloured	.	7.9 (11.1)	.	0.055
White		15.6 (5.8)		
Education				
High school		8.4 (11.2)		
Undergraduate	.	10.0 (9.8)	.	0.727
Post-graduate		6.7 (12.3)		
*Other**		9.9 (10.7)		
Marital Status				
Single/divorced/widowed	.	9.0 (10.2)	.	0.665
Married		7.8 (12.6)		
Employment				
Employed full time/part time	.	10.9 (9.4)	.	0.398
Unemployed/Studying		8.1 (11.3)		
Previous Admissions				
Yes	.		7.0 (3.5-13.5)	0.544
No			9.0 (0.0-17.0)	
Number of days admitted prior to starting the group	-0.053		.	0.639
Change in Mood	0.27		.	*0.016
Change in discharge preparedness	0.306		.	*0.006

**Other in Education includes Diploma, college certificate, NQF levels*

Correlation analysis of the age variable was conducted using Spearman's rank-order correlation due to the non-normal distribution of the MHSES change scores and interpreted using Cohen's benchmark indicating a significant weak correlation. Further analysis of the age variable revealed a possible outlier (participant 11, change in MHSES = -29) as seen in Figure 4.3. The possible outlier was tested as a true observation by analysing it with other demographic data, there was no difference in the significant

statistical impact on the p-value of other demographic data when it was excluded; therefore, this outlier was included throughout all statistics. Figure 4.4 depicts weak negative correlation (r = -0.26, p = 0.023) between age and change in MHSES. Indicating modest outcome that younger ages have a greater shift in MHSE after engaging in OTIGM group.

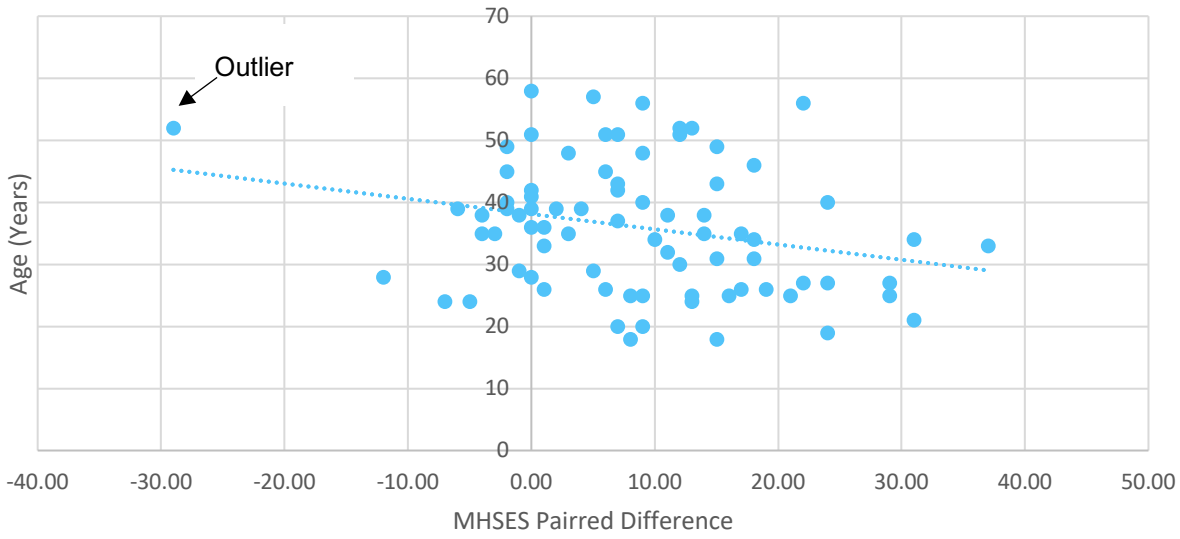


Figure 4.4 Correlation between age and change in Mental Health Self-Efficacy scale scores

Table 4.2 indicates that 'previous admissions' did not indicate a significant difference between this period of hospitalisation being their first admission or whether the participant has had a previous admission using the two-sample Wilcoxon Signed-rank test (0.544). It is noted that the change in MHSES median scores and interquartile range of participants in their first admission (9.0, 17.0) are higher compared to those who have had a previous admission (7.0, 10.5). Change in mood was noted to have weak positive correlation with the MHSES (r=0.27, p=0.016) indicating that improvements in mood have a measurable yet limited influence on MHSES scores.

Table 4.3: Linear regression of demographic variables with changed Mental Health Self-Efficacy scale scores

Variables	Unadjusted coefficient (95% CI)	P-value	Adjusted coefficient 15% (95% CI)	P-value	Re-adjusted coefficient 5% (95% CI)	P-value
Age (Years)	-0.22 (-0.44-0.010)	***0.040***	-0.19 (-0.40-0.01)	0.059	-0.20 (0.40-0.00)	0.055
Gender					.	.
Female	4.64 (-0.71-10.00)	**0.088**	1.80 (-3.51-7.05)	0.506		
Race					.	.
Black	-7.00 (-14.22-0.24)	**0.058**	-6.04 (-12.92-0.85)	0.085		
Education		0.913				
Undergraduate	1.65 (-4.61-7.90)	0.601	.	.	.	.
Post-graduate	0.78 (-5.69-7.26)	0.810				
*Other**	1.56 (-6.21-9.32)	0.691				
Marital Status			.	.	.	.
Married	0.03 (-4.92-4.98)	0.989				
Employment			.	.	.	.
Employed	1.82 (-4.03-7.70)	0.474				
Previous Admissions			.	.	.	.
Yes	-0.90 (-5.91-4.11)	0.721				
No. days admitted prior to starting the group	-0.67 (-1.368-0.027	**0.059**	-0.36 (1.05-0.32)	0.297	.	.
Change in mood	3.01 (0.87-5.14)	***0.006***	2.04 (-0.15-4.23)	0.067	2.40 (-0.28-4.51)	*0.027
Change in Discharge Preparedness	1.12 (0.28-2.00)	***0.010***	0.57 (-0.30-1.44)	0.194	0.84 (0.00-1.68)	0.051

**Other in Education includes Diploma, college certificate, NQF levels*

Table 4.3 displays the results of the linear regression analysis investigating the association between demographic variables and the outcome variable: the change in MHSES scores using both unadjusted and adjusted regression coefficients (with 95% confidence intervals). The unadjusted model reflects statistically significant predictors of age (p-value = 0.040), race, change in mood (p-value = 0.006) and change in discharge preparedness (p-value = 0.010). However, in the adjusted model including variables with a p-value < 0.150 (age, gender, race, no. days admitted prior to starting the group, change in mood, and change in discharge preparedness) suggesting that the unadjusted associations may have been influenced by confounding factors. On further investigation, multicollinearity was noted between 'Change in Mood' and 'Change in Discharge preparedness' variables reflecting a significant, weak positive correlation (r = 0.25, p-value

= 0.028). To address multicollinearity, the Principal Component Analysis (PCA) was applied by reducing the number of variables; therefore, the model was re-adjusted to only include statistically significant variables with p-value < 0.050 (age, change in mood and change in discharge preparedness). The re-adjusted model revealed change in mood to be the only statistically significant variable (β = 2.40, p-value = 0.027) reflecting that it is a key predictor of MHSES scores. These adjustments provide a clearer view of the predictors that maintain strong associations with MHSES scores, even when accounting for potential confounding factors. Therefore, the findings for all variables except the change in mood and age, failed to reject the null hypothesis that demographic factors affect the change in MHSES scores.

4.2.5. Objective 3

To establish the relationship between self-efficacy and discharge preparedness in MHCUs diagnosed with MDD after participating in OTIGM intervention.

The results and data analysis associated with the relationship between MHSES, and discharge preparedness is explained in this section to address objective 3.

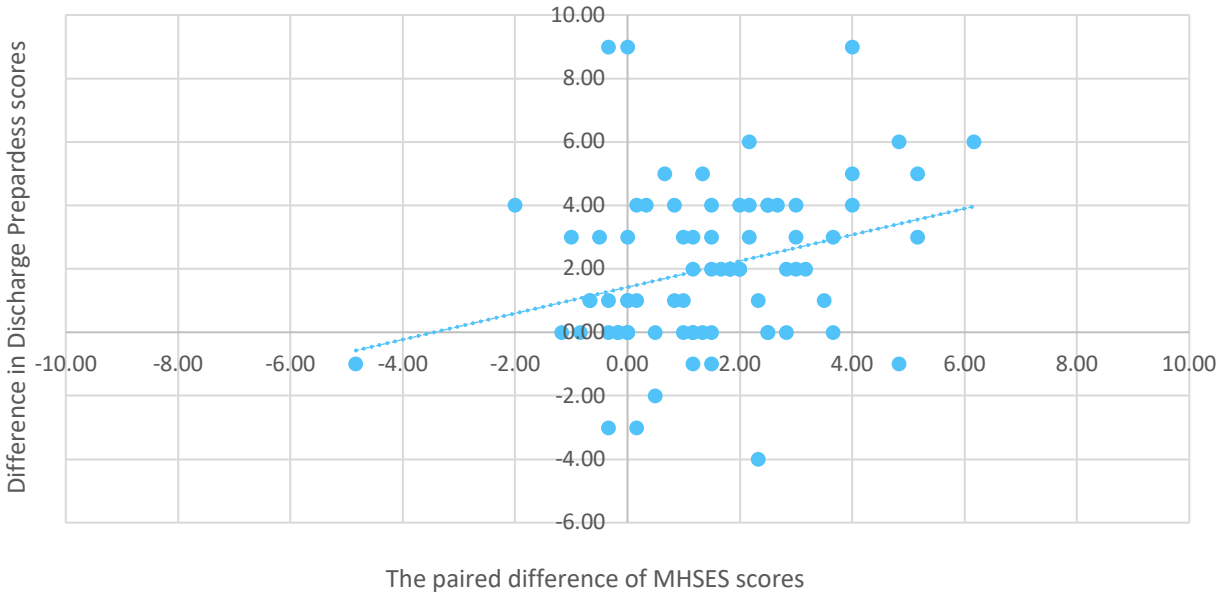


Figure 4.5 Correlation between change in Mental health self-efficacy scale scores and discharge preparedness scores

Figure 4.5 illustrates the weak positive correlation using Spearman's rank-order correlation (r = 0.306, p-value = 0.006) between the change in MHSES scores and change in discharge preparedness ratings indicated in Table 4.2. Indicating modest positive change in MHSE is associated with positive change in discharge preparedness. The regression analysis in Table 4.3 further identified that the discharge preparedness variable is not a predictor of MHSES in the re-adjusted model (β = 0.84, p = 0.051). Therefore, the null hypothesis which stated that There is no statistically significant correlation between MHSES scores for self-efficacy and discharge preparedness ratings after the OTIGM was rejected.

4.3. Qualitative Strand: Perceived influence of the OTIGM intervention on self-efficacy to impact discharged preparedness

4.3.1. Introduction

The findings in the quantitative strand, support the quantitative results and revealed that overall, there was an increase in self-efficacy and discharge preparedness after attending OTIGM intervention. Therefore, the qualitative results aim to further explore the perceived impact of the OTIGM intervention on self-efficacy to impact discharge preparedness among MHCUs diagnosed with MDD to address the fourth objective of the study. Directed content analysis of semi-structed interviews was used, guided by operational definitions derived from the literature on self-efficacy. The data was aligned with the pre-determined themes (OTIGM, self-efficacy and discharge preparedness) and categories (APPENDIX N: Predetermined codes and definitions); additional codes were also identified and integrated to authentically represent the participant's subjective experience.

4.3.2. Demographics of the Participants

Ten of the thirteen (76.92%) interviews that were conducted met the inclusion criteria.

Table 4.4: The demographic variables and rating scores of MHSES and Discharge Preparedness of each participant.

Participant ID	**Age**	**Gender**	**Race**	**Marital status**	**Education**	**Employment**	**Admission**	**Mood**	**Discharge preparedness rating**	**MHSES score**
Bonnie	46	Female	Black	Divorced	Post-Graduate	Employed	Second	Content	10	60
Cecilia	39	Female	Black	Married	High School	Employed	First	Neutral	6	58
Emmett	39	Male	Black	Single	High school	Employed	First	Neutral	4	55
Megan	55	Female	Black	Single	Post-Graduate	Employed	First	Content	5	50
Miriam	28	Female	Black	Single	Diploma	Employed	First	Content	6	39
Muriel	49	Female	Black	Married	Post-Graduate	Employed	First	Happy	10	52
Nikita	35	Female	Black	Married	Under-Graduate	Employed	First	Neutral	1	33
Ruben	58	Male	Black	Married	Post-Graduate	Employed	First	Neutral	5	41
Sabina	41	Female	Black	Single	Post-Graduate	Employed	Fourth	Neutral	6	37
Tabea	34	Female	Black	Single	Post-Graduate	Employed	First	Content	4	45

The participant's ages in the qualitative data range from 28 to 58 years (mean = 47years), reflecting the young adult and adult population. Eight of the participants were female, while two were male. All participants were black, employed and, at minimum, two participants had obtained a matric certificate, with eight holding additional qualifications. Five were single, one divorced, and four were married. Except for two participants, the rest of the participants were admitted to a psychiatric hospital for the first time. All group members' mood ratings were on the mood scale's positive leg. Post-group scores of Discharge Preparedness rating ranged from 1-10, and MHSES ranged from 33-60. Interestingly, Nikita has the lowest discharge preparedness (1) and MHSES score (33) however, in her interview she contradictorily shares positively on going home: *"So I'm just content with what I've learned here, with what I've gained, especially with the [OTIGM group], to say, Nikita, 'this is the [OTIGM intervention] the pieces are all yours, so put them together." This* highlighted a possible bias, social pressure or change in self-efficacy between completing MHSES and the interview.

4.3.3. Objective 4

Three themes were constructed following the directed content analysis to meet the fourth objective of exploring the perceived impact of the OTIGM intervention on self-efficacy to impact discharge preparedness among MHCUs diagnosed with MDD. These three themes describe the three areas of analysis in this study: the OTIGM, self-efficacy and Discharge Preparedness. 'Synergy of the therapeutic program' and 'Duality' were identified as additional areas of interest emerging from inductive coding, which were discussed within the themes. Categories were identified under each theme and allocated appropriate codes through rigorous analysis and peer review as depicted in Table 4.5 and Figure 4.6, which depict the frequency and organisation of themes, categories and codes.

Table 4.5: Summary of Coded Segments and Participant Mentions for each Theme, Category, and Area of Interest

Theme	**Number of coded segments**	**Participants Mentions**
Theme 1: OTIGM	(606)	
1 Experiential learning,	94	10
2 Group dynamics create a Safe Space	291	10
3 Self-Agency	221	10
Theme 2: Self-efficacy	(203)	
1 Mastery	29	9
2 Physiological and Emotional States	63	10
3 Vicarious Experience	33	9
4 Verbal Persuasion	34	10
5 Evidence of Self-Efficacy	44	10
Theme 3: Discharge Preparedness	(203)	
1 Readiness	99	10
2 Application	72	10
3 Future planning	32	8
Areas of interest:		
Synergy of therapeutic program	19	8
Duality	27	8

In Table 4.5, the numbers allocated to themes reflect the number of instances of coded segments, the highest number does not always reflect the most important categories

depending on the depth and breadth of the coded segments. These themes, with their corresponding categories and relevant codes, are depicted in Figure 4.6. Following Figure 4.6; each theme is reported on separately, indicating categories, including appropriate quotes.

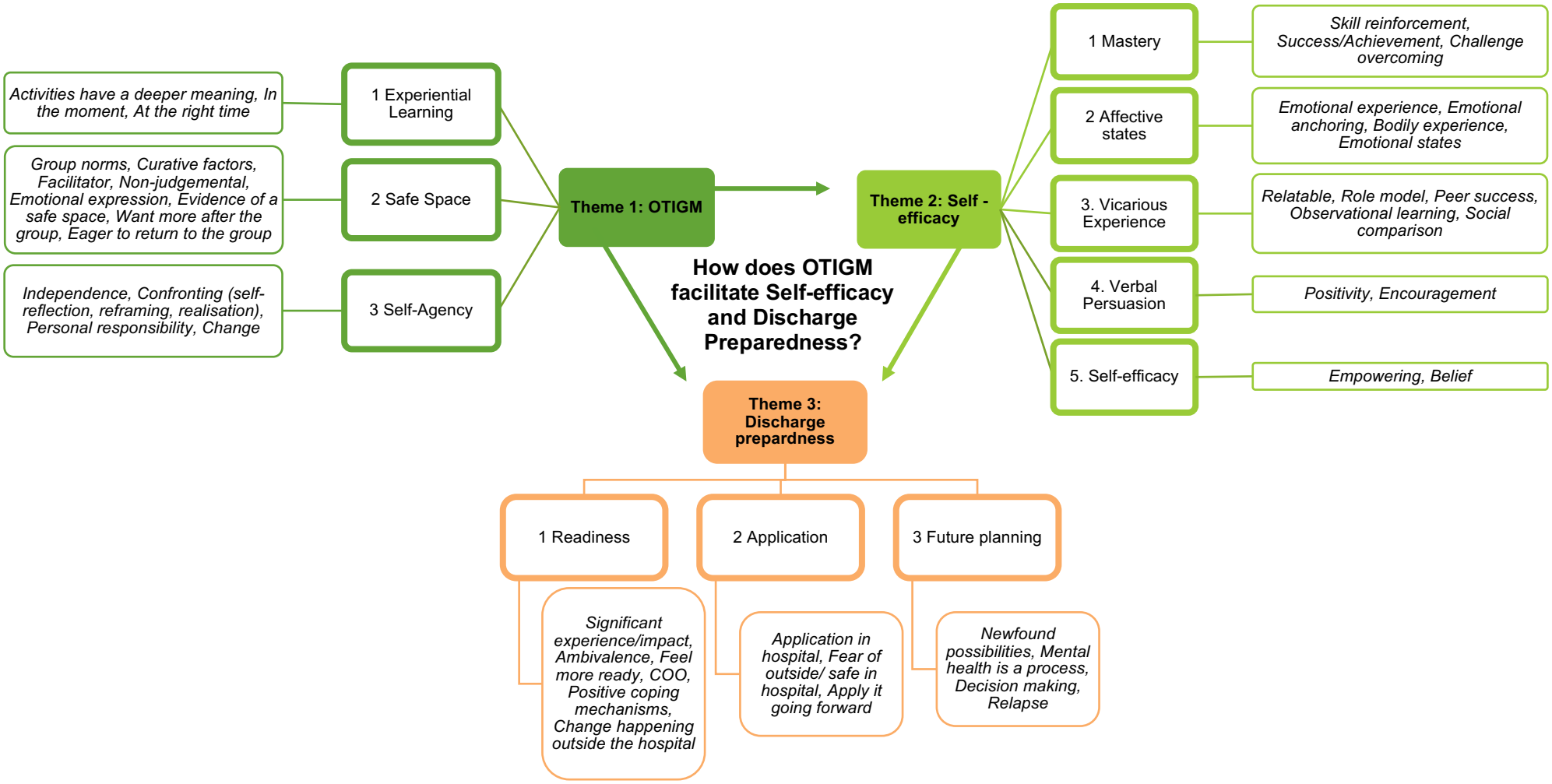


Figure 4.6 An overview of the content analysis results reflecting on themes, categories and key codes

Figure 4.6 presents the themes, categories, and key codes for the three themes including OTIGM, self-efficacy, and discharge preparedness. Each of these categories is connected to specific codes. Each theme is discussed in detail in each section by expanding on categories, identifying commonalities and contradictions, define relevant codes with supportive selective quotes to provide a holistic view of the emerging data. All the participants shared on the significant experience they had in the OTIGM intervention which was evident by comments on the OTIGM such as *"[it's a] lifetime skill" -Muriel, "It is worth it, and it is working" - Nikita, and "[it] helps people, I'm 34 years old, and I learnt on Wednesday how to let go of things because of [OTIGM group]"* -Tabea.

4.3.3.1. Theme 1: Occupational Therapy Interactive Group Model (OTIGM)

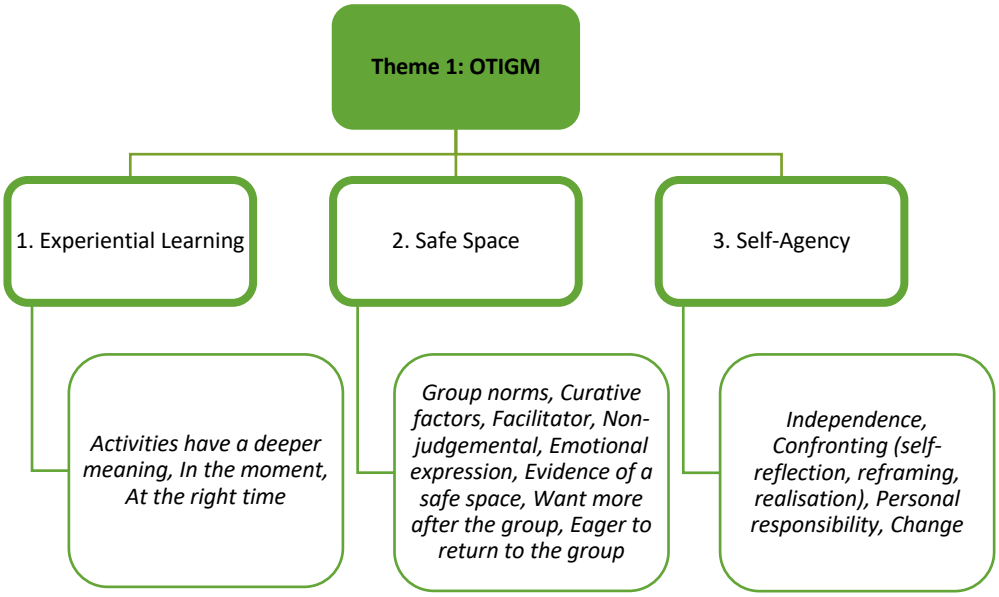


Figure 4.7 The categories and key codes of Theme 1: Occupational Therapy Interactive Model

The first theme explores the elements of the OTIGM and the evidence of the model's principles which creates a therapeutic environment for experiential learning to take place, for participants to experience the group as a safe space, and to foster self-agency within participants. This theme provides evidence for the therapeutic principles of the OTIGM. Figure 4.7 presents each of these categories with their corresponding key codes. 1) Experiential learning highlights the use of activities in the here and now. The use of the group dynamics, role of the facilitator and curated group atmosphere, which developed a 2) Safe space in which participants are able to face being confronted, find their independence and have opportunity for change, ultimately developing and 3) Self-agency. Describing how participants moved from being passive recipients of support to becoming active agents of their growth to build self-efficacy.

Category 1: Experiential Learning

Experiential learning within the OTIGM model emphasises the power of engaging in hands-on activities that foster self-discovery, skill development, and emotional growth. The quotes in this section highlight the participants' acknowledgement that the activities used in the group have deeper meanings, serving as catalysts for reflection and insight into their personal experiences and challenges. Most of the participants expressed surprise at the rich meaning they gained from the activities, as described by Ruben:

> *"And at first when she [the facilitator], she was doing this, we thought we are playing, but whereas when we go and sit down and make some reflection, then you can see there were benefits in that activity"*

Almost all the participants noted the experience of 'skill-building through fun' which emphasised that *"playful games that will teach us something*" -Sabina, which allowed for improved engagement as noted by Muriel "*The key lesson there was that we forgot that we are uncomfortable because we were active."*

Participants noted how their perspectives shifted to see the activities as metaphors for real-life challenges in learning and reflecting on their perceptions. Muriel championed the experience of experiential learning in a description of an experience where she confronted emotional blocks and learned to move forward despite feeling "stuck." The meaningful conversation on emotional expression in the group enabled her to understand that

"… whatever we are going through, we can still be able to continue living while navigating what we're going through." -Muriel

Many of the participants shared similar experiences as Muriel recognising the value of 'in-the-moment' awareness, aided by the facilitator's technique of illumination by prompting and highlighting their behaviour during the activity which led to uncovering a deeper meaning. Tabea discovered the impact of holding on to past problems through an activity that involved leaving behind "popped balloons", symbolising released burdens.

"Then as we were about to [pick up the popped balloons], she [the facilitator] goes, 'Don't you dare pick up your problems, have you learned nothing?' Oh, that was so hilarious. That is the day that I learned to let go of things and that I cannot control people." - Tabea.

Sabina experienced realisation that she only needs to concentrate on one thing at a time in a stress-inducing ball-throwing activity to address theme of control.

"I was so anxious because I was looking at everybody, not minding the person who was supposed to throw the ball at me. So, she [the facilitator] just said, 'Don't look at anyone else. Concentrate on her [the person throwing the ball to you] only. Concentrate on one thing because you can't do everything.' That, that, that. And after that, when I started concentrating on the lady who was throwing a ball at me, I became so calm." - Sabina

Indicating that bringing the participants' awareness to the 'here and now' allows for group members to realise the impact of their actions and allow for change to happen in the moment. Bonnie and Cecelia noted another technique used by the facilitator to bring their awareness to the 'here and now' by prompting group members to identify and deal with current emotions when they were feeling and experiencing these emotions.

"[when identifying our emotions], she [the facilitator] told us not to say: 'I'm okay'…. she needs your current emotions, not yesterday, or what brought you here, your current- yes. So, I think it was easier too, because it's what I feel at the moment. No, it can't hide. If I'm sad, I'm sad." - Cecelia

Participants shared the different meanings that they found from the structured experiences in the activities, noting the key code 'skill reinforcement', which identified

skills of practicing patience, self-awareness, and emotional regulation. Nikita mentioned the initial confusion in understanding the activities, highlighting the need for patience and a gradual shift towards internal motivation.

“Patience is the key because with the [group], you, you can say, like the first games or the things that the OT is making you do, you’ll think, but is she bored or what?” - Nikita

Also highlighting external locus of control to the activities that the facilitator is ‘making’ the group do activities, whereas Mirriam realised that she should not always listen to the facilitator and rather apply her own thinking, after direct prompting from the facilitator.

"Obviously, in the moment was like, you’re my lecturer [facilitator], so I’m going to follow your lead… So, being able to just apply my own thoughts and not always have to wait for being told what to do.” - Miriam.

The experiential learning component also emphasised the value of a group over individual setting, as participants reported that groupwork fostered a sense of belonging and safety.

“The experience of it [holding onto hurtful emotions] in a group session, I don’t think it would help a single bit when you do it individually…. You know, you are not alone, people are experiencing the same.” - Megan

The participants highlighted how the group discussions after the activity allowed for the opportunity to reflect on their actions through the eyes of other group members to provide different opinions and perspectives. The opportunity for learning from activities is strengthened by the relationships and trust built amongst the group members, and one participant described the meaningful relationship among group members.

"… [the group] created a bond, between the ladies [group members]. It has strengthened us, individually." - Megan

Reflecting on the value of groupwork and being empowered by others, therefore indicating that the group process is important to follow to create a safe space for group members to openly engage in experiential activities.

Category 2: Safe Space, Group dynamics of the OTIGM contribute toward a safe space.

Participants frequently described the supportive environment cultivated in the group as a *“safe space”* -Bonnie, -Tabea, -Megan. This section provides evidence of the supportive environment created by the facilitator through the OTIGM principles, including group norms, curative factors, and therapeutic self-use. Creating a safe space is important for participants to be vulnerable and open towards sharing, receiving feedback, listening to others, and where *“I can be me”* - Emmett. The key codes for ‘safe space’ included comments where the facilitator created a supportive atmosphere by ensuring confidentiality, managing conflicts sensitively, and creating a non-judgmental environment where group members feel comfortable expressing themselves.

At the onset, the facilitator created an opportunity to establish group norms and boundaries to set expectations about the group. Participants identified several boundaries, including “respect”, “no judgment”, and “time management”, and the most noted boundary was “confidentiality”.

> *“Because we were given that assurance that what I only want to say is it’s confidential. It must remain here; it must not go out… that’s why we are so open to each other.” - Emmett*

This emphasises that confidentiality fostered ‘trust within the group’, a sentiment echoed by several participants.

While the group norms assisted the group in trust and building a sense of safety, the facilitator also guided participants on this process by following the therapeutic process using curative factors. Curative factors are an element that is a foundation for the OTIGM therapeutic process to develop conducive group dynamics for therapy, *"I think it was how [the facilitator] was handling the, the, the group that brought us closer."* - Cecelia. These principles and their outcomes were evident from the findings: Cohesion emerged as the most frequently noted factor (43 occurrences), followed by instillation of hope (25), universality (17), development of socialising/interpersonal/communication skills (14), imitative/observational learning (11), imparting information (10), altruism/encouragement (10), catharsis/emotional release (6) and recapitulation of the family group (3). Many

participants specifically highlighted the value of listening to each other, and the group giving *"they [the group members] give you their ear, you express yourself"* - Emmett fostered a deeper connection.

The relationships that developed within the group were marked by a sense of familiarity and support, with participants using terms like *"buddies,"* - Nikita and *"close family,"* is what Emmett used, to describe their connections. Having no previous or future relationship with group members facilitated openness, as Nikita expressed,

> *"Like right now, I'm opening up to somebody that doesn't know me. Of which I don't think you can be judgemental…". - Nikita*

The advice and shared experiences contributed to a sense of universality evident by codes like 'not alone', 'we're all in this together', and 'oneness'. Ruben observed that the "*group was selected with a purpose",* as they could relate to one another's challenges.

All participants reported that the facilitator's characteristics were crucial in fostering a relaxed and safe environment that encouraged vulnerability. Participants described the facilitator as attentive, empowering, flexible, gentle-natured, knowledgeable, non-authoritative, and reassuring. Tabea remarked,

> *"She [the facilitator] had the spirit of this is your safe space. She didn't say it; she made it feel like that... Because when we first started, I was just like, I'm not a sharer...., but then as class went on 30 minutes later there, I was pouring my heart out in the room for the strangers." -Tabea*

The facilitator's encouragement of emotional expression, such as allowing participants to be themselves, to cry and share their feelings. Mirriam added on feelings of assurance due to the client-centred focus of the OTIGM as it was structured around her personal goals.

> *'I also like that [the facilitator] did say that she's not going to plan our topics. She said she was only going to plan them after we write our goals. .... That was nice, because it's very rare for classes, I feel like, to be centred around what they know about you.'" - Miriam*

A variance of experience was noted where in the same 'pebble activity': Emmet noted how his problems impact his focus; Miriam shared how it illuminated that she could think

for herself rather than following others; and Muriel noted how she was empowered as she *“can still continue, even when there are, things are happening”* -Muriel. This variability also highlights a client-centred approach as it allows the group/individual to identify what they find significant to empower them rather than impose on facilitator-desired outcomes and beliefs suggesting that not all group members may find the same level of support or success from the same activity or group experience.

The safe space enabled emotional expression, with Sabina sharing

> *“I was free. I felt like crying and I cried. It didn’t matter to me who was looking at me or whatever…. In the group I would not pretend.” - Sabina,*

Emmett noted the gradual release of emotional burdens, saying

> *“Because now um, that load that was on my shoulders it’s not that totally out, bit, bit by bit I’m off-loading it” - Emmett.*

Whilst many group members mirrored Emmett’s and Sabina’s experience, some participants acknowledged the challenges of sharing initially but noted the benefits in hindsight*: “Yeah, it was a bit difficult to share my pain…It [emotional expression] helped me, and I now know that sharing can help you heal.”* - Cecelia. This divergence underscores a significant aspect of ‘duality,’ illustrating both the advantages and challenges associated with vulnerability.

The safe space was due to a cumulative effort of the facilitators’ therapeutic use-of-self and the development of group dynamics and opportunities for emotional expression created an environment where members felt safe to engage. One group member felt so safe and supported by the group she was eager to return each day *“I was always looking forward to, I wouldn’t even finish my lunch.” - Nikita.* Contrarily Bonnie shared *“I was afraid of going into [OTIGM intervention]. But once we started, yeah, she [the facilitator] made us feel comfortable”.* Six of the participants voiced a desire for continued engagement beyond the group, highlighting the effectiveness of the safe space established. Another group member highlighted the duality and change in her perception *“you go in [to the group] there dragging, they’re pulling you in. But by the time [the group ends] you, you don’t want to leave, you don’t want it to end“ - Tabea.* The supportive environment established within the group not only facilitated open expression but also laid the

foundation for the development of self-agency. As participants felt secure in sharing their thoughts and emotions, they began to recognise their capacity for personal growth and change.

Category 3: Self-Agency

Self-agency emerged prominently within the participants' accounts, revealing a transformative journey toward autonomy, self-awareness, and personal accountability. From the initiation of the group process, the facilitator highlighted*, "'Guys, it's voluntary'"* -Tabea*,* to reveal to group members that they are responsible for their engagement and outcomes from the group. The operational definition to guide these findings were instances when participants mentioned setting their own goals, taking responsibility for their actions and progress. This section provides evidence to support definition of self-agency where participants articulated a newfound capacity for independence, self-reflection, acceptance of personal responsibility and, ultimately, change facilitated by the therapeutic process of activities, discussions, support and illumination highlighted in Category 2) Safe space. The revealed sub-codes of self-agency, such as 'independence', 'realisation', 'acceptance, 'reframing', and 'control, clarify the various avenues through which participants developed self-agency.

Self-agency was evident in participants' willingness to confront personal issues, often prompted by self-reflection and group feedback. For instance, Tabea discussed the benefit of being gently challenged by the facilitator on her self-limiting behaviours

> *"If you're doing something, not toxic per se, but something that is leading you back..., she [the facilitator] will not necessarily call you out, but she'll tell you that what you're doing now" - Tabea.*

The process of confronting destructive behaviour highlights the importance of self-reflection in enabling participants to independently recognise and address maladaptive patterns. Through the confrontation of the activities, verbal feedback from the group and illumination from the facilitator, group members came to many realisations such as "*I can make a decision"* - Ruben, - Nikita, - Megan, *"I have more to be grateful for than I thought"* -Tabea, -Megan, -Bonnie, "*I'm not stuck"* -Muriel, - Megan and the most occurring realisations was '*awareness of destructive coping skills/thoughts/behaviours'* - All.

Through confrontation and realisations group members were able to accept and reframe their outlook as noted by seven of the ten participants. Tabea explained *"I didn't know that I, I'm, a forgiver. I always thought that I held grudges."* -Tabea. Opportunities created by the facilitator for reframing to challenge established/societal/irrational beliefs was a crucial component of the therapeutic process. Allowing participants to re-evaluate societal norms that may have contributed to their difficulties. Ruben acknowledged that,

"There is no strong man. Because people are taking all the burdens and say, 'I'm strong'. So, I'm realising that I'm not strong…. I just woke myself like to those myths to say, 'men don't cry'."

Challenging gendered expectations has hindered belief in emotional expression. Tabea reflected on the impact of cultural perceptions on her own health-seeking behaviour towards her symptoms of depression.

"I thought it [mental illness] was a white person problem because you all have too much time on your hands. But I actually saw, you know, that I haven't been to work I've exhausted all sick annual leave days."

Nikita shared a similar insight but related to the negative past experiences of conflict by creating an opportunity to experience positive, healthy conflict.

"… not all conflicts are bad; it depends on how you handle it." - Nikita

And Cecelia reframed her thoughts to realise she could have internal boundaries.

"Yes, if they think I'm useless, I told myself, no, I'm not useless." - Cecelia

Cecelia and Ruben described the benefit of group support and prompting questions to shift from suicidal thoughts/plans and hurting others to self-acceptance, self-love, and improved health-seeking behaviour.

Through acting on reframing beliefs, the majority of the participants noted seeing a change in themselves compared to the start of the four-day group intervention.

"The negative became the positive… the way you came in [to the OTIGM group] was, it was different than the way you go out." -Sabina

Ruben described 'change' in an instance where two younger group members were withdrawn from the group and the group challenged and provided honest feedback to

encourage change. One of these individuals displayed genuine commitment to change, while the other resisted. Providing an important insight that not all group members achieve the same therapeutic outcomes despite being in the same group for four days, linking to variability of experiences. This example connected to the code of 'at the right time', which captures the need for willingness where active engagement was needed to benefit from the group process; merely being in the group does not create change. Bonnie's account exemplified her passive reliance on therapeutic interventions in her previous admission to a conscious effort to internalise and act upon therapeutic insights after engaging in OTIGM intervention in her current admission.

> *"Unlike that time [previous admission], I was in denial. I didn't want to- to internalise the help or the therapies and [OTIGM group]… So, it's like I expected people to, to solve my problems while I'm here. But actually, they're giving me or teaching me how to cope with my problems when I'm out there. …. So, this time, I've intentionally listened, I've intentionally told myself that… I need to make sure that I listen, I do, and I live it…" -Bonnie*

This journey of personal responsibility depicted by Bonnie's experience revealed an important element of self-agency as it developed the realisation for acceptance to manage problems or circumstances without relying on others to solve them. The group acted as a mirror, providing feedback in a supportive yet challenging space, enabling participants to provide areas where they could take control of their lives. For example, Muriel explained, *"[My group experience] was actually a great one because then I got feedback from the group on how to try and navigate or reduce [my problems]".* Cecelia described her personal experience as a shift in perspective of control during the group and how group members sometimes pointed out where she had overlooked her agency. The newfound independence developed within the group further allowed participants to think for themselves and not blindly accept feedback*. "But not to say that you must just do whatever they're telling you at the end of the day. So, you need to be reasonable." - Nikita.* Despite realisations and efforts at reframing, one participant, Bonnie, expresses an ongoing struggle with fully embracing self-worth: *"[the] most overwhelming thing is that I can't, I still can't acknowledge that I deserve to be happy. I still can't acknowledge that I am not my problems " -Bonnie.* Reflecting on an inner conflict, although she has intellectually experienced happiness in the sessions, internalising happiness remained challenging.

4.3.3.2. ***Theme 2**: Self-Efficacy*

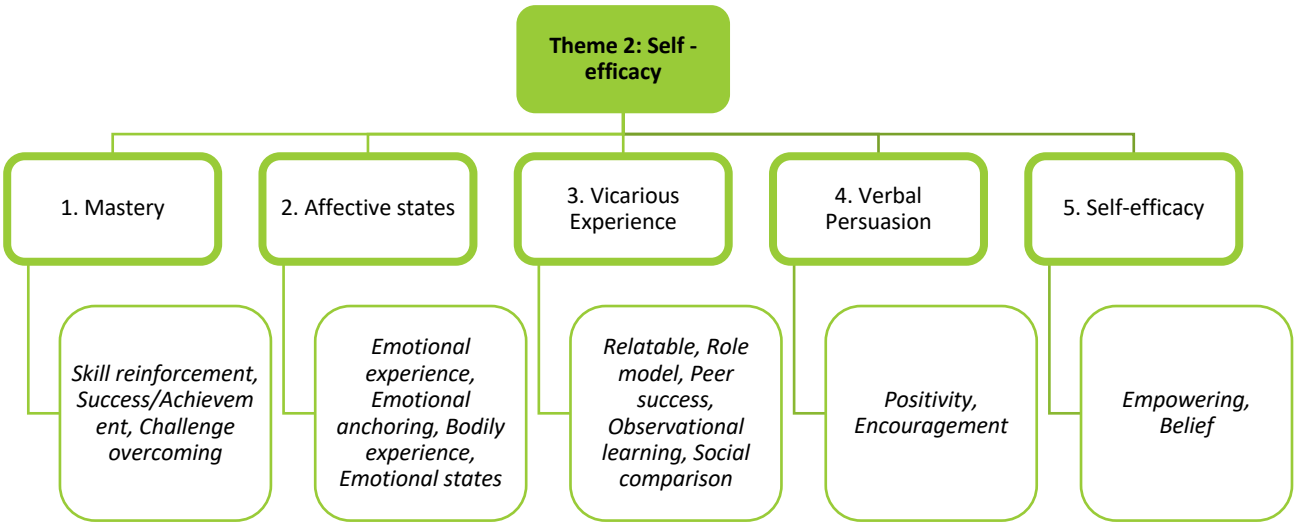


Figure 4.8 The categories and key codes of Theme 2: Self -efficacy

Building from the foundational elements of the OTIGM model and the establishment of a safe space and self-agency provided a platform for the development of self-efficacy. Figure 4.8 illustrates categories of theme 2 which is comprised of the 4 sources of self-efficacy as well as evidence of overall self-efficacy. All four sources of self-efficacy were noted in the findings: 1) Mastery of experiences, 2) Affective states, 3) Vicarious experience and 4) Verbal persuasion. Participants reported feeling more competent as they learned, applied and mastered new skills, navigated complex emotions, observed peer successes, and received reinforcement from both facilitators and fellow group members. Overall, 5) Self-efficacy was evident by codes of newfound belief in themselves, empowerment and hope.

Category 1: Mastery of experience

Through the various group activities, participants gained hands-on experiences that reinforced their skills and sense of achievement to reinforce a belief in their capabilities. Through learning from the activities in the here and now, participants had experiences where they were able to practise skills, overcome challenges and find success.

> *"I think maybe It's, it's, it's a huge difference when somebody tells you to do some one, two, three, and then you walk away, but she [the facilitator]*

told me, and she said, 'Do it', and I did it. I think when you act on it, … you really absorb it." - Sabina

By acting and succeeding in these activities, participants built a basis for personal accomplishments, reinforcing a belief in their own abilities. Sabina's comment in the above quote, "I did it," after following the facilitator's encouragement encapsulated structured opportunity of mastery, where success in task-completion further boosted Sabina's self-confidence. In comparison to Bonnie's experience of therapy sessions during her previous admission where *"… people are just talking and I'm just getting all this information. How am I going to actually put it in action or practically do it?"* - Bonnie

Sabina, Nikita, Muriel, Emmet and Bonnie explicitly encountered and overcame personal challenges during the sessions, reinforcing their sense of resilience. Bonnie's reflection on forgiveness illustrated a mental shift in overcoming inner struggles.

"[I] forgive myself for trying to hold on to pain that doesn't serve me" - Bonnie

The most cited improvement of skills was 'communication' as one of the most practised skills in a socio-emotional group like the OTIGM. Communication skills included codes such as 'listening', 'expressing themselves openly' and 'interacting with different types of people'. Activities encouraged open dialogue, active listening, and team collaboration, which assisted participants in gaining confidence in expressing themselves and interacting with others. Nikita shared an example from a group activity that reflected on a moment where she practised listening skills with group members.

"We will listen to each other, and then we will practice it. Yes, we'll practice it, like, as I'm saying, like the that game that we played for the hands [human knot activity]. ... stand back, listen, we do that and then try." - Nikita

Participants even noted reinforcement of skills learnt from other groups or sessions as an opportunity to practise and utilise learnt skills in the OTIGM group, especially emotional regulation skills as noted by Megan.

"I already started using it [breathing technique] soon after the particular lecture that it actually; it actually helps." - Megan

Category 2: Affective states

A significant part of self-efficacy development emerged through participants' engagement with emotional responses triggered by stressful situations, influencing the participants' perceived competence and anxiety and low mood during activities as explained in Bonnie's experience of a shift in emotional experience:

"[in the activity] I'm vulnerable, I'm weak, because I was thinking about the pain too much, so it made me feel like, you know, unsettled… So, yeah, I learned that I must deal with things, you know, one step at a time. So that I am not overwhelmed …" - Bonnie

Symbolic activities explored in the OTIGM intervention assisted participants to address emotional and mental challenges through physical actions. Bodily experiences during activities further cemented this impact, with participants, including Megan's reflection on the letting go balloon-popping activity, which illustrated how the activity symbolised the weight of burdens, creating a tangible and real-life experience.

"We were holding the balloons like this, with your hand outstretched… It's exhausting. And the facilitator said, 'Imagine holding a balloon [with] all the negative emotions that we were feeling… No, no, no, I'm letting this go. I am absolutely letting this go!" - Megan.

"The popping of the balloon was such a significance for me because it felt as if those things were gone. Don't get me wrong, I don't have any delusions of grandeur or anything. I know that problems are still going to exist in the world." -Tabea.

This not only alleviated physical sensations of tension but also fostered a mindset of release and inner peace. Emmett described his process of grief and feeling like he was saying goodbye to his loved ones, leading to relief.

"I felt like, just like I was really with them. And saying goodbye to them, yeah, I felt very much good because that was for the first time having in this process of feeling, doing things like that" - Emmett

Participants experienced a range of emotional states within the group grouped into sub-codes of stressful feelings of 'anxiety' and 'overwhelming' to positive feelings of 'pride',

‘happy’, ‘peace’ and most commonly ‘relief’. Engaging in these activities with self-reflection in group discussions allowed for a duality of emotional processing: on the one hand, participants were faced with real-life challenges and difficult emotions, *“I had never encountered such a challenge. And I think it felt overwhelming because I was, I was not in control”* -Megan, while on the other hand expressing *“newfound happiness and peace and serenity.”* -Tabea.

All participants shared the experience of ‘fun’. “*So, it [OTIGM group] was fun, it was relaxing, it was an exciting experience, the adrenaline...,”* -Bonnie. Positive and enjoyable emotional experiences were noted as Tabea described *“[OTIGM] has taught me to enjoy things that I honestly thought they were miniscule, but they’re not.”.* Sabina shared how she and her fellow group members had not experienced positive emotions for a long time. *"[the facilitator asked us], “When the last time, when was the last time we had fun?’ No one could answer that question”* -Sabina Furthermore Sabina, Mirriam and Megan also shared on the freedom they experienced through opportunities where they were able to express their ‘inner child *“laughing and everything, jumping up and down like little kids.”* -Sabina. Participants further noted being encouraged to continue feeling positive and hopeful rather than sad and helpless, as many participants identified with before starting the group.

“I don’t wanna get home and start all over again. Being moody and, I didn’t like myself. But I wanna be that energetic lady that I saw the other day in [the group activity].” – Sabina

Category 3: Vicarious experience

Vicarious experience was evident when MHCUs observed others perform tasks successfully, especially those perceived to be similar to oneself enhances belief in one’s own abilities as participants noted, *“I saw myself in her”* - Tabea. Witnessing relatable experiences of others’ succeeding and facing challenges, allowed group members to see themselves in others. One participant described the experience of openness and personal expression creating a positive impact through relating to another group member.

“So, by them sharing, I think I deserved to allow myself also to express myself…. She also encouraged me, because I think she’s strong. The way she opens up herself, made me [open up]” - Bonnie

Observing peers perform tasks or navigate personal challenges resonated and inspired participants to confront their own struggles. Highlighting the development of role models in the group space by observing others go through challenges and succeeding, which encouraged them to also want to attempt challenges.

> *"I was able to relate with what she was saying to my current situation. It was like she was talking to me...* ***It gave me a sense of power; it arose like a fire in me that, of course, I can. What made me think I couldn't? Of course, I can, I can overcome this****!"* - Megan

Miriam added about how listening and interacting with the group members allowed her to learn more than just what the facilitator had planned as she learnt from watching others *"It was surprising because it's just like you can actually notice a lot just from sitting and listening".* Participants added how hearing others' success stories encouraged them and helped them recognise negative coping behaviour in themselves and were able to develop solutions. Altruism was also evident by experiencing achievement when others succeeded *"…seeing, you seeing them being liberated from that, it's part of a celebration as well for you. It's part of a celebration as well for you."* -Megan.

The process of social comparison was noted by six of the ten participants who shared a healthy perspective shift, with participants recognising that their struggles, though significant, were manageable compared to others.

> *"When you hear other people's pain, it gives you another perspective of your own things that you're going through. So, if somebody can let go abuse, then I'm sure I can let go of people just gossiping about me." - Tabea*
>
> *"My problems were so small, although daunting. So, it's a process that really humbled me." - Muriel*

Bonnie even shared how she initially did not want to come to the OTIGM intervention as she had done it during a previous admission but seeing *"How other people were anxiously looking forward to the group made me excited to go again."*

Category 4: Verbal Persuasion

Supportive and positive feedback was integral to strengthening participants' beliefs in their ability to succeed as the group environment fostered through affirmation, encouragement and constructive feedback. Participants noted how the affirmations they received in the group positively influenced their self-view, helping them to recognise qualities they hadn't seen before in themselves. *"I cannot work alone. We cannot work in silos in this life, we need each other."* - Nikita. Tabea expressed how meaningful it felt to have someone facing even greater challenges recognise and affirm her, boosting her self-belief.

> *"It's something that does something to your soul… That somebody who's going through so much more than you are, [and] can see the strength in you, strength that you can't even see in yourself." - Tabea*

Cecelia's experience explored in the category of self-agency contributed to the impact of the group's observational feedback. Similarly, some participants observed how sharing feelings with the group and being met with empathetic reactions validated emotions and reinforced a sense of belonging and confidence. Confrontation and illumination noted in feedback in experiential learning and self-agency in theme 1 were noted to be important for participants to realise their destructive behaviour or irrational thinking to shift perspective to believe in themselves. Therefore, verbal persuasion in the group context can also include criticism.

> *"I did receive very positive feedback, not to say there were no criticism, but encouragement as well." - Nikita*

Category 5: Evidence of Self-efficacy

The culmination of experiences of all the sources of self-efficacy left participants with a stronger belief in their own self-efficacy. Table 4.6 offers a concise summary of how each source of self-efficacy was cultivated through the OTIGM intervention supported by participant quotes.

Table 4.6 A Table summarising the Occupational therapy interactive group model principles that facilitated each source of self-efficacy with qualitative evidence.

The four sources of self-efficacy (Bandura)	***How it was facilitated in OTIGM***	***Qualitative Examples***
1) Mastery of Experiences	• Group environment • Experiential activities (deeper meaning and playfulness) • Facilitator • Overcoming challenges in the here and now • MOHO feedback loop (Kielhofner & Forsyth, 1997) • Promote doing (Wilcock, 1998)	*"I think when you act on it, … you really absorb it…" - Sabina* *"We will listen to each other, and then we will practice it." - Nikita*
2) Physiological and Emotional States	• Group environment (safety leads to vulnerability of affective experiences) • Experiential activities (symbolic activities) • Group norms (clear expectations) • Illumination of emotions. • Opportunities for emotional expression	*"We were holding the balloons like this, with your hand outstretched.… It's exhausting. And the facilitator said, 'Imagine … holding a balloon [with] all the negative emotions that we were feeling….. for a week, or a month, or a year… No, no, no, I'm letting this go" -Megan.* *"[in the activity] I'm vulnerable, I'm weak, because I was thinking about the pain too much, … So, yeah, I learned that I must deal with things, you know, one step at a time. So that I am not overwhelmed". -Bonnie*
3) Vicarious Experiences	• Group environment (safe space allows for vulnerability) • Experiential activities • Observational learning of group members experiences • Listening to others • Roles models (universality and recapitulation of the family group) • Social comparison	*"So, by them [group members] sharing, I think I deserved to allow myself also to express myself…. She also encouraged me, because I think she's strong. The way she opens up herself made me [open up]" -Bonnie* *"When you hear other people's pain, it gives you another perspective of your own things that you're going through. So, if somebody can let go of abuse, then I'm sure they can let go of people just gossiping about me." -Tabea*
4) Verbal Persuasion	• Group environment (universality and cohesion) • Experiential Activities • Facilitator (modelling) • Encouragement and Affirmation • Advice • Confrontation (constrictive feedback, challenge perception) • MOHO feedback loop (Kielhofner & Forsyth, 1997)	*"I did receive very positive feedback, not to say there were no criticism, but encouragement as well." - Nikita* *"… [the group] will give you advice maybe or maybe I put something on the, out of my control, but it's actually in my control… So now I know I must not stress with the things that I can't control. -Cecelia*

Group environment, experiential activities were noted to be key contributors to self-efficacy as they are included under all four sources of self-efficacy as noted in table 4.6. Prompting all four sources of self-efficacy led to participants feeling empowered to handle daily challenges, advocate for themselves, and trust in their own capabilities to better navigate MDD symptoms. The OTIGM allowed the space where *"The negative became*

the positive." Nikita expressed this transformation by sharing her feeling of *"getting my groove back",* and others like Muriel expressed that even though on the outside she is reflecting positively, it has also translated to her inner self: *"Positive, happy, energetic Yeah, inside, I project well outside, but I feel the relief inside, inner faith." -Muriel*

The empowerment gained from the group allowed participants to embrace self-advocacy and courage as they prepared to face the world post-discharge.

"I am so much empowered …. it's my life at the end of the day." - Nikita

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Shifting in the group from a sense of helplessness to hopefulness was evident throughout interviews as all of the participants reported feeling more hopeful and instilled positivity *"It means that I'm gonna also pass the stage [of depression] and I'll be fine"* -Sabina. The group atmosphere encouraged openness, allowing participants to share their experiences and learn from one another, thus reinforcing their belief in their ability to manage their mental health challenges. "*I do have the tools to manage the depression."* - Tabea

Participants shared that they felt like themselves again after their experience of a mental health episode.

"[OTIGM group] reminded of myself of who am I, what am I made of" - Nikita

As noted in topics of client-centredness and change, each participant has different experiences of the groups and therefore varying levels of transformation yet all the participants' reflections in the interviews revealed a marked improvement in their ability to manage mental health challenges and embrace self-reliance. Nikita's realisation that she can *"face the world and deal with [her] anxiety"* demonstrated her growing belief in her capacity to cope. Bonnie's statement captured the heart of the participant's collective experience, which underscored the empowerment and resilience gained through the intervention.

"I was now encouraged and more positive about how I can get to a happy place while I'm dealing with my problems" -Bonnie

4.3.3.3. ***Theme 3:*** *Discharge Preparedness*

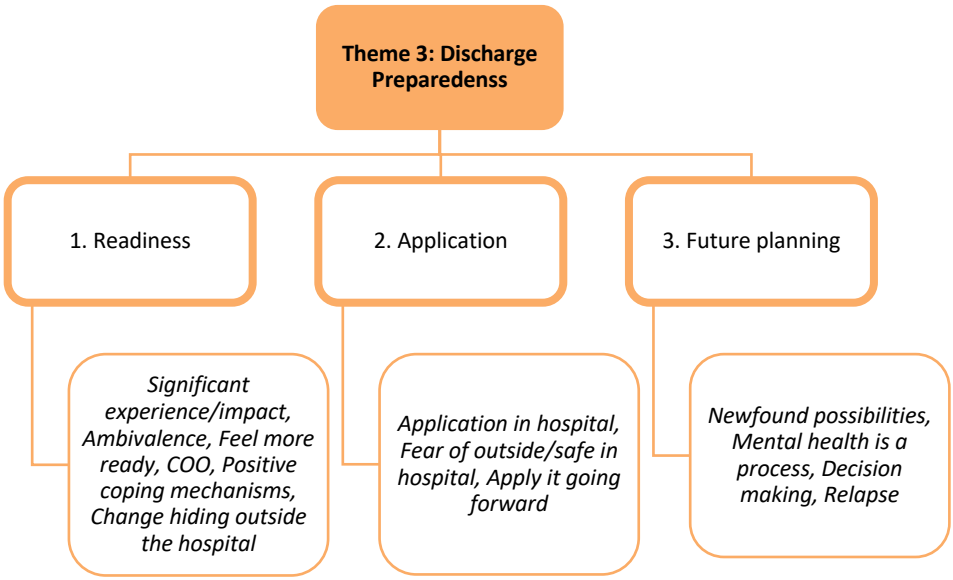


Figure 4.9 The categories and key codes of theme 3: Discharge preparedness

This theme, as depicted in Figure 4.9, reflects on participants' preparedness for discharge and how participants' experiences in the OTIGM group influenced their self-efficacy to face challenges relating to MDD outside the hospital. Participants linked feelings of 1) readiness to their significant and impactful experience in the OTIGM intervention. Reflecting on participants' 2) application of skills learnt in the group to both inside and outside the hospital. Further demonstrating how the OTIGM intervention contributed to participants' 3) future planning to manage life post-discharge to deal with ongoing mental health challenges and the realities of relapse. Overall, this theme uncovered the ambivalence of feelings including mix of optimism, determination, and caution about the realities of transitioning back into everyday life.

Category 1: Readiness

"I'm ready to face the world" - Cecelia.

Participants expressed varying levels of readiness as they approached discharge, highlighting the complexities of preparing for life outside the psychiatric hospital. Some felt empowered by the skills they learned, for example, Miriam noted,

"I feel more at ease about managing it [my mental health], feel more hopeful because… I'm here [in the hospital] to learn and to identify certain things for me to prevent it getting there [extreme level].'"

Nine of the participants expressed ambivalence when reflecting on the realities of discharge. Despite mixed feelings on readiness, participants expressed foresight on the realities of discharge with an optimistic outlook.

"For now, I'm scared... I don't want to go back to that place. So, I don't know when I get home what's going to happen. I am so anxious about that mountain. But I'm hopeful at the same time." -Sabina

Ambivalence is an important code as it reflects the participant's duality in their readiness for the different areas of their lives when going home, there are certain aspects they are ready for, others that they are not ready for. *"I am ready to be discharged, but I'm not ready to go back to work… So that's why I'm saying that I'm not ready."* -Tabea. Emmett reflected that while he made progress in the group he does not want to go home as he is enjoying the safe hospital environment. Megan noted feeling prepared but acknowledged hesitancy and safety in the hospital environment,

"Am I immediately ready to be discharged? I don't think so. I'm feeling content in here [the hospital], but I think a few more days where I can really be confident about going out there and face the world." -Megan

The participants reported improvements in their areas of occupation, evident by sub-codes of social participation', 'health management', 'leisure' activities, and 'sleep'. It was evident from the codes that the biggest area of occupation the participants mentioned was social engagement, which was an echo of communication skills from category 1 Mastery in theme 2. Muriel shared that she believed she will better engage within her role as a friend due to increased motivation,

"I'm expecting now when my friends say, 'Hi, I've got a birthday for my child'. I will wake up and shower and dress up and go buy the gift and catch up with my friends." -Muriel.

Bonnie and Muriel voiced on behalf of a few participants on recognising the importance of prioritising personal health management, as it enhanced ability to manage mental,

emotional and physical health, ultimately allowing for balanced lifestyle and improved childcare, socialising and job performance.

Overall, participants experienced a holistic improvement in their daily functioning, which was also positively impacted by the area of interest in 'synergy of the group program' which promoted a healthy and routinised daily structure, "*The centre [hospital] has given me those skills that when I go home."* -Ruben. Participants commented on improved sleep hygiene, medication management, consistent mealtimes and the social environment. Reflecting on the OTIGM group together with therapies outside of the group, Muriel was able to deal with the *"root/core"* of her problems with psychologists and psychiatrists.

"We were able to learn more things that we've learned, outside in other classes, if not, it was able to exemplify it [what we learnt]" - Miriam

Positive coping mechanisms played a vital role in helping participants manage their mental health beyond medication. They learned to identify their emotions and take proactive steps to address them, as Tabea noted,

"By knowing how to identify that I'm not okay, knowing what mood I'm in and knowing what I need to do to get out of a certain mood." - Tabea

The developed self-awareness allowed individuals to regulate their emotions and engage in positive practices such as leisure activities, spending quality time with family, setting boundaries, and using self-affirmations. Bonnie shared her surprise at discovering these tools while also needing continued support,

"I didn't know that I could have some coping mechanisms... I thought the only option was to go to a psychologist or psychiatrist. So, there were things that I could do that could help me just to control the disorder [MDD]". She will also "… keep in touch with my doctor if I feel stuck." - Bonnie.

Highlighting how the OTIGM group introduced them to alternative ways to cope with challenges, reducing dependence on medication or therapy.

Category 2: Application

Participants noted that the hospital provided a "*confined*" space - Muriel where they felt safe to practice their skills; however, the thought of implementing those same strategies in their everyday lives sparked anxiety, which was highlighted in the code of ambivalence. Four participants voiced concerns about how others would react to their changes, fearing the stigma of others thinking they are *"mad"* or changing their behaviour towards them and *"tiptoe"* around them. Muriel highlighted this stigma, sharing,

> *"Knowing how stigmatised mental health is, and my level in corporate, and how it might impact- 'Which one, that crazy one, did she take her pills today?' That's how sad mental health is not accepted as a condition that can be treated."*

Improved confidence to socialising was noted, such as interaction with other patients in the hospital, building friendships with group members, and being more open to sharing their feelings in response to others and on their stressors. Three participants shared about the change in their approach to communicating with others outside of the hospital in noticing they are more patient and understanding due to the OTIGM, which Nikita described in an example of when she was talking to a loved one on the phone, *"My manner of approach, it has actually changed".* Sabina expressed how she was more empowered to socialise in the hospital, and with people being around her, it's easier to develop relationships when people are around rather than needing to seek them out.

> *"It [OTIGM] really did help me. You know, when I got here, I was not really talking with my roommate… I think I am going to be able to socialise. But I struggle with that part…. I don't really have friends." -Sabina.*

This illustrated the challenge of transferring the sense of safety and connection found in the hospital to the complexities of social interactions outside the walls. One participant expressed feeling a lack of control over the discharge process, stating, *"I might be out of here on Tuesday… [or] next week Friday probably is when I'm going to be leaving. Because that would be when my 21 days is up, I think".* -Tabea. The use of the phrase *"I think*" underscored the uncertainty that Tabea is experiencing regarding her discharge timelines. This ambiguity hampered participants' ability to prepare adequately for their

transition home, both in terms of logistical arrangements, mental readiness and future planning.

Participants highlighted the practical application of skills learned in the group in the hospital environment. Participants mentioned practising skills like journalling to express emotions: *“I didn’t wake up in a good mood, but I wrote down why, I started journaling, and then I said ‘no, this is not going to make my day.’” - Tabea.* This approach not only helped her articulate her feelings but also empowered her to take control of her day. Overall, participants expressed that their days were more enjoyable (Bonnie) and articulated a desire to carry positive energy (Muriel) facilitated during the OTIGM group beyond the hospital.

Participants expressed a strong commitment to applying the skills and insights they gained during their hospital stay to their lives after discharge. Bonnie highlighted the importance of self-care, stating, *“being intentional about doing the things that uplift me,”* while Nikita affirmed her focus on setting boundaries for herself. Many participants planned to continue practices like journaling and addressing conflicts to build respectful communication. Miriam shared her proactive approach, saying,

> *“I’m not getting discharged yet, but I’m still able to take that advice right now. And just know so that when the ‘time comes, I don’t have to start seeking advice. It’s already something that I kind of already know.” - Miriam.*

Participants also expressed wanting to share what they learnt with others once they are discharged, like boundaries, communication, and emotional openness, and to recreate some of the activities from the group with others to connect and have fun with loved ones. Collectively, these reflections illustrate a commitment to ongoing growth and proactive mental health management, viewing their hospital experiences as a crucial foundation for their future well-being.

> *“You know, so instead of complaining about life and I’m gonna- obviously, my problems are not going to just go away- but I’m not gonna let them fester within me anymore” -Tabea*

Category 3: Future planning

As participants looked towards their futures post-discharge, they expressed a sense of newfound possibilities, recognising the potential for a healthier and more fulfilling life. Participants emphasised the importance of decision-making in their recovery *"The choice is all mine...."* -Megan. Recognising that they must take active steps towards managing their mental health to avoid relapse. Tabea articulated her ambitions, stating,

> *"Managing your depression, I just thought I had to get over it. I didn't know that it's one step at a time, one day at a time …I want to join a gym, I want to, I want to live healthier, I want to eat healthier." - Tabea.*

They expressed a heightened awareness of their symptoms and the need to act before issues escalate. Emmett noted, *"I'll definitely recognise the symptoms"* and committed to addressing them early, stating, *"I won't allow them to restart."* This proactive stance indicates a newfound determination to take responsibility for his healing journey. However, the strong motivation to maintain progress made during his admission, *"I think I'm going to work so hard that they [symptoms] do not come back" -Muriel,* failed to acknowledge the potential challenges that may arise upon discharge. Which contrasted with the realistic approach and consideration surrounding the return-to-home journey, *"We all make mistakes, it's a human error, it doesn't mean that it's the end of the world." - Nikita*. For instance, Cecelia shared, *"Going back home will always remind me about the [attempted] suicide. The way I feel now, I don't think that will ever bring me down, what happened, happened."* This statement underscored the complexity of recovery, suggesting that while participants were committed to moving forward, they must also grapple with the weight of their past experiences and have compassion with themselves. Bonnie echoed this sentiment by asserting her desire to be practical about her emotions and intentions, stating, *"I want to be practical about the things that I've learnt here."* This desire for growth underscores the participants' understanding that mental health is a process that requires ongoing effort and reflection. Cecelia acknowledged this journey, remarking,

> *"Yeah, I know I'm going to meet [the] same people… the only change is me, how I see things, how I take things….even at work [and] at home, it's the same people." -Cecelia.*

highlighting her commitment to altering her perspective and response to challenges. before coming to the hospital.

4.3.4. Connection of Qualitative Themes

The relationship between the themes of the qualitative findings are summarised and illustrated in Figure 4.10 which visually depicts the relationships between OTIGM, self-efficacy, and discharge preparedness to reflect how these elements interplay to support mental health recovery in MHCUs with MDD.

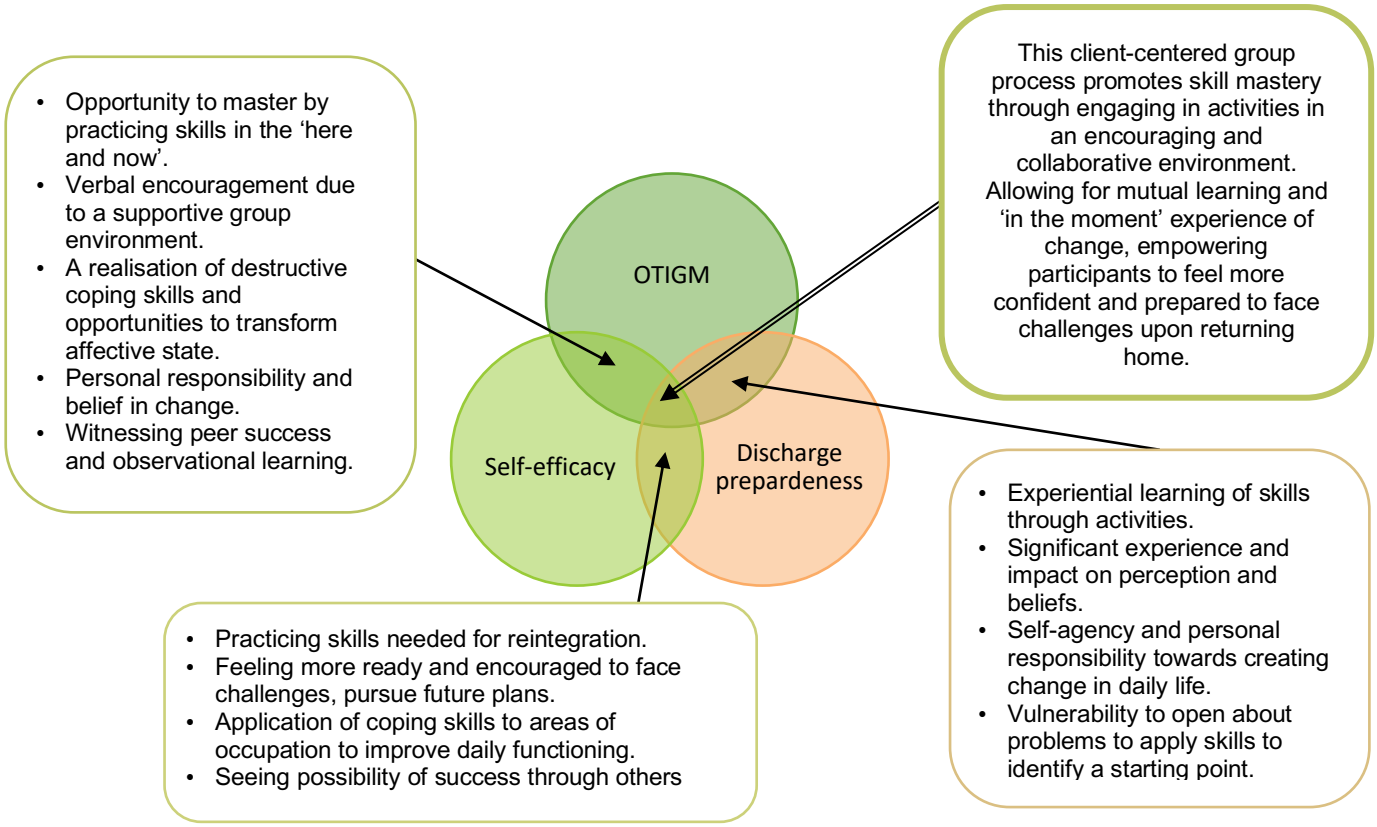


Figure 4.10 The intersection of qualitative findings between the three themes: Occupational therapy interactive group model, self-efficacy and discharge preparedness

The overlapping areas in Figure 4.10 summarise that through the OTIGM, participants built self-efficacy through gaining confidence and self-agency by practising coping strategies and recognising their successes and support from peers. These elements empowered participants to feel more prepared for discharge and equipped with the skills necessary for reintegration into daily life. The process includes both emotional growth (inner self-trust and peace) and practical readiness (application of skills to daily

functioning), enhancing their ability to handle the challenges they may face post-discharge. The findings reveal that the OTIGM provided a client-centred, experiential learning environment where individuals could practice skills in the present moment, receive peer support, and gain verbal encouragement. The environment fostered personal responsibility by helping participants to believe in their ability to change and manage their challenges.

4.4. Joint Displays of Quantitative and Quantitative Strands

In line with the convergent parallel mixed methods design (Creswell, 2015), the following section presents joint displays that visually integrate quantitative and qualitative results. Quantitative results demonstrated a statistically significant increase in MHSES scores following the OTIGM intervention and qualitative data provided further insight into participants' experiences of enhanced self-efficacy and discharge readiness. This approach strengthens the interpretation of findings by bringing together numerical changes in self-efficacy and discharge preparedness with participants' subjective experiences of the OTIGM group intervention. Each table is followed by a brief summary highlighting how the two strands converge, diverge or expand on one another. Deeper interpretive integration and linkage to existing literature are provided in the Discussion chapter along with narrative integration.

Table 4.7 Joint display of quantitative and qualitative strands to highlight change in self-efficacy and discharge preparedness

	Quantitative Results	***Qualitative: Key categories, findings***	***Interpretation***
Change in Self-efficacy	Statistically significant change in MHSES scores of 8.60 (10.036), p-value < 0.001 *after participating in OTIGM.*	*Evidence of the promotion of all four sources of self-efficacy evident (Mastery, Vicarious experience, Verbal persuasion, and Physiological and Emotional States)*	*Convergence* *both data strands support positive shift in self-efficacy*
Change in Discharge Preparedness	Statistically significant change in discharge preparedness rating 2.01 (0.56) p-value < 0.001 *33.33% reported no change or a decrease in discharge preparedness.*	*Readiness, Application, Future planning, highlighting positive change in disagree preparedness, however feelings of ambivalence evident*	*Convergence* *Duality of positive change towards discharge preparedness accompanied by hesitancy*

Table 4.7 integrates the quantitative and qualitative results for Objective 1, which explored changes in self-efficacy and discharge preparedness following OTIGM intervention. Quantitative findings demonstrated statistically significant improvements in MHSES, and qualitative themes aligned by illustrating how the OTIGM facilitated the four sources of self-efficacy. Discharge preparedness was also noted statistically significant change further acknowledging that not all participant noted improvement in perceived readiness for discharge. Qualitative data highlighted this nuance, revealing that despite measurable improvements, some participants experienced emotional hesitancy about returning home, underscoring the layered experience of recovery in MDD.

Table 4.8: Side-by-side comparison presenting the change in Mental Health Self-Efficacy scale scores per question with a supportive qualitative quote.

MHSES Question	***Change in MHSES scores***	***Complimentary Qualitative Statement***
*You can keep your stress, anxiety, or depression from **interfering** with the things that you want to do?*	1.66	*"I will wake up and shower and dress up and go buy the gift and catch up with my friends." -Muriel. [explaining how she will now engage in her role as s friend by going to birthday parties]* *"Managing your depression, I just thought I had to get over it. I didn't know that it's one step at a time, one day at a time …I want to join a gym, I want to, I want to live healthier, I want to eat healthier." -Tabea*
*You can do the **different tasks** and activities needed to manage your stress, anxiety, or depression to reduce your need to see a doctor?*	1.69	*"I didn't know that I could have some coping mechanisms... I thought the only option was to go to a psychologist or psychiatrist. So, there were pieces of things that I could do that could help me just to control the disorder [depression]*" -Bonnie
*You can do things **other than just taking medicine** to reduce how much your stress, anxiety or depression affects your everyday life?*	1.10	*"So that when you go now to the outside world, at least you have that skill, that this, I can do it this way." -Ruben*
*You will have **moderate amounts of time where you do not experience** stress, anxiety, or depression?*	1.04	*"You know, so instead of complaining about life and I'm gonna- obviously, my problems are not going to just go away, but I'm not gonna let them fester within me anymore" -Tabea*
*You can make your days at least moderately **enjoyable**?*	1.64	*"[OTIGM intervention] has taught me to enjoy things that I honestly thought they were miniscule, but they're not." -Tabea* *"They [my days] are more enjoyable." -Bonnie*
*You will be able to **effectively manage** any stress, anxiety, or depression that you do experience?*	1.30	*"I do have the tools to manage the depression." -Tabea* *"It means that I'm gonna also pass the stage [of depression] and I'll be fine" -Sabina.*

Table 4.8 highlights the alignment between each individual MHSES questions' improvements and participants' qualitative reflections. Providing examples of how MHCUs internalised skills introduced during OTIGM group intervention such as shifting their beliefs about coping, understanding of self-management and expressing renewed hope for functional engagement post-discharge. The integration therefore reflects convergence and expansion as the statements highlight why these therapeutic gains were meaningful.

Table 4.9 Joint display of quantitative and qualitative strands to show the relationship between age, mood and discharge preparedness with self-efficacy.

	Quantitative Results	***Qualitative: Key categories, findings***	***Interpretation***
Age	Weak negative corelation 0.26, p = 0.023. *Indicating that older participants experienced smaller increments of change in MHSES*	*No direct qualitative finings linked to age*	*None* *no qualitative information therefore rather explained by literature*
Mood	Weak positive correlation r = 0.27, p = 0.016 *Indicating positive change in mood is associated with positive change in MHSES* Mood is a predictor of MHSE β = 2.40, p-value = 0.027	*Physiological and Emotional States and perceived positive shift in mood*	*Convergence* *Positive change in mood is noted in both strands*
Relationship between Self-Efficacy and Discharge Preparedness	Weak positive correlation r = 0.306, p-value = 0.006 *Indicating positive change in MHSE is associated with positive change in discharge preparedness.*	Development of 4 sources of self-efficacy contribute to preparation for discharge through mastering skills, carrying over, encouragement/advice, positive shift in mood	*Convergence* *Modest relationship of self-efficacy and discharge preparedness supported by ambivalence for carry over post-discharge.*

Table 4.9 identifies limited qualitative finings to support quantitative results of age. Mood noted to have a weak correlation with MHSES and change in mood developed by Physiological and Emotional States which is relevant to MDD. Table 4.9 integrates quantitative findings on the relationship between self-efficacy and discharge preparedness with qualitative findings illustrating how the development of self-efficacy sources supports participants' readiness to manage post-discharge challenges. The convergence of these data strands highlights a modest relationship of these variables, diminished by participant's feelings of ambivalence toward real-world application after discharge from the hospital environment.

4.5. Conclusion

The results and findings section addressed each of the study objectives. Quantitative data indicated a statistically significant positive change in MHSES scores and discharge preparedness after MHCUs with MDD participated in the OTIGM intervention. Among demographic variables, only age and mood change were significantly associated with improvements in self-efficacy, while other factors showed no notable effects. A weak but statistically significant positive correlation was found between self-efficacy and discharge preparedness, suggesting a modest association between these variables. The qualitative findings explored the perceived impact of the 4-day OTIGM group, with participants describing experiences that reflected all four sources of self-efficacy (mastery experiences, affective states, vicarious experiences, and verbal persuasion). These insights assisted to illustrate how the structure and principles of the OTIGM contributed to participants' developing confidence, while also revealing a duality of readiness and hesitation towards discharge. Overall, both the quantitative and qualitative findings addressed the research objectives and provided a basis for understanding the development of self-efficacy in relation to discharge preparedness following participation in the OTIGM. The next chapter will integrate the quantitative and qualitative findings with literature to explore their relevance and implications in greater depth.

CHAPTER 5: DISCUSSION

5.1. Introduction

This chapter discusses and integrates the quantitative and the qualitative findings of the parallel convergent mixed methods study linked with existing literature (Creswell, 2015). To explore how the Occupational Therapy Interactive Group Model (OTIGM) intervention fostered self-efficacy, enabling Mental Health Care Users' (MHCUs) with Major Depressive Disorder (MDD) to confidently face mental health challenges to be better prepared when refuting home. The research aimed to highlight the value of OTIGM groups in the acute private psychiatric setting, where there are limitations in the continuation of services after discharge (Hegedüs *et al.*, 2020; Silaule & Casteleijn, 2021).

This chapter follows a narrative integration discussion structure supported joint displays form the results and findings(Creswell & Clark, 2017). Quantitative objectives one, two, and three are discussed in separate sections, with objective four serving as a connecting thread through the inclusion of subjective perspectives. Therefore, each section presents relevant quantitative and qualitative findings, which are then interpreted together to identify points of convergence, divergence, and expansion, and contextualised within existing literature and prior research This structure allows for direct comparison and interpretation of both data strands under each section, enabling a richer understanding of the OTIGM's impact.

The first section of this chapter discusses the improvement in self-efficacy and discharge preparedness after participants diagnosed with MDD engaged in the OTIGM group intervention, highlighting how the identified principles of the OTIGM fostered the four sources of self-efficacy. The second section explores the influence of demographic factors, specifically mood and age, on self-efficacy. The third section examines the relationship between improved self-efficacy and discharge preparedness, including participants' ambivalence about returning home and the complexities of future planning. Together, these integrated findings provide a deeper understanding of the development of self-efficacy and the complexities of discharge preparedness after OTIGM group engagement.

5.1. Demographics

The demographic profile of participants in this study primarily reflects employed, black, unmarried females with higher education qualifications; consistent with other South African studies in private, psychiatric occupational therapy studies (de Witt *et al.*, 2020; Meyer, 2022). Previous research (Magaard *et al.*, 2017) in a similar psychiatric setting, also reported a higher number of females compared to males which attributed to increased health-seeking behaviour. Similarly, the high rate of employment among participants may impact internal and external return-to-work pressures, effecting discharge readiness (Davidson, 2018; de Witt *et al.*, 2021). Most participants in this study (69% quantitative; 80% qualitative) were admitted to a psychiatric hospital for the first time, de Witt *et al.* (2021) noted, first-time admissions may present additional challenges, including limited insight into their mental health needs, lower engagement in the hospital's therapeutic programme, and more difficulty adjusting to the hospital environment. The age distribution of participants in this study (mean of 36 years for quantitative and 47 years for qualitative strand) falls within the highest risk age bracket for MDD in South Africa (Tomlinson *et al.*, 2009). While this demographic may not represent the broader population affected by MDD, it mirrors MHCUs with MDD population int the South African private sector, which is mostly limited to individuals with access to private medical aid (Statistics South Africa, 2020). Overall, these demographic characteristics situate the study's findings in the context of a private, acute psychiatric hospital.

5.2. Change in Self-Efficacy and discharge preparedness after engagement in OTIGM intervention (objective 1)

The first objective of the study identifies the change in self-efficacy, using the change in MHSES and the change in discharge preparedness in MHCUs with MDD after participating in the OTIGM intervention. The range of qualitative post-test MHSES scores (33–60) demonstrated diverse findings, capturing varied perspectives. While the participants also engaged in other therapies between pre- and post-test, the qualitative data reveals that the principles of the OTIGM had a positive effect on the level of self-efficacy which work in tandem with other therapies as noted by the synergy of the hospital program. Therefore, highlighting the important contribution of holistic treatment and interventions to contribute towards one another in acute psychiatric treatment.

5.2.1. Self-efficacy

This study used the MHSES tool to show a statistically significant improvement in MHSE (p-value < 0.001) from pre-test to post-test after participants engaged in the OTIGM. Complimented by qualitative findings where all participants reported on a shift from a sense of helplessness to hopefulness in dealing with depression as noted in Table 4.7. Participants perceived that the OTIGM group had a profound and lasting impact, with many describing it as a valuable, transformative experience in their perception of their mental health and ultimately feeling like themselves again compared to admission. Supporting previous findings in which OTIGM was found to instil hope towards a meaningful life (Davidson, 2018).

The findings in this study align with the 'human open system' of the Model of Human Occupation (MOHO), which highlights the interplay between an individual's internal subsystem and external environmental feedback in managing MDD symptoms to support occupational engagement (Kielhofner & Forsyth, 1997). Participants reported that group therapy provided a unique space for self-reflection and growth *aligning with* OTIGM principle that "The Whole is Greater Than the Sum of its Parts" (Fouché, 2021). This finding is consistent with Yalom & Leszcz (2005), who emphasise the therapeutic value of group dynamics in fostering emotional processing and social learning. Notably, participants highlighted that the safe and supportive group environment facilitated meaningful interactions that enhanced self-belief and confidence, which aligns with research suggesting that peer support and shared experiences unique to group therapy contribute to improved mental health outcomes compared to individual therapy (Toledano-González *et al.*, 2018). The structured yet flexible nature of the OTIGM as voiced by the participants allowed for the cultivation of healthy external feedback, which, according to Crouch (2021), is essential for facilitating positive changes in self-perception and occupational functioning. Furthermore, participants' reflections suggest that engaging in group activities provided a more impactful experience than individual therapy alone, "*I don't think it [the activity] would help a single bit when you do it individually.*" - Megan. Echoing findings that collective engagement enhances motivation and reinforces behavioural change (Bandura, 2001).

Personal causation, aligning with the construct of self-efficacy, is an individual's perceived competence and belief in oneself to use skills (Cole, 2018) participants expressed feeling empowered and more confident. Self-efficacy was revealed to be a good indicator of mental health and is associated with a reduction of psychosocial symptoms as MHCUs believe they are capable of managing stressful and negative events (Ngooi *et al.*, 2022; Rabani *et al.*, 2011). Aligning with the findings of this study where participants voiced making progress in dealing with their depressive symptoms to the extent that *"I think I'm going to work so hard that they [MDD symptoms] do not come back"*- Murial. Additionally, Table 4.8 highlights that the components of the MHSES showed a significant (p-value < 0.001) positive change in belief in experiencing 'time without symptoms' (1.04) and perceived ability to 'manage symptoms' (1.39). Therefore, just as personal causation is integral to MOHO, self-efficacy is identified to play a crucial role in enhancing MHCUs mental health and well-being, equipping them with the confidence needed to manage chronic mental health conditions such as MDD (Ngooi *et al.*, 2022). Therefore, focusing on enhancing self-efficacy within occupational therapy interventions is valuable as MHCUs develop greater autonomy and confidence in skills needed to address depressive symptoms (Ngooi *et al.*, 2022).

A significant improvement across all questions of the MHSES (p-value ≤ 0.001) is apparent in subjective experiences after OTIGM intervention as noted in table 4.8. The elements of MHSES include elements reducing the interference of MDD symptoms (APA, 2013) on engagement, using a variety of coping strategies, managing depression beyond medication, experiencing relief from symptoms, enjoying daily life and effectively managing stressors. The greatest change in MHSES scores (1.69) was improved insight into doing different activities to manage symptoms. The results align with the study by Ngooi *et al.* (2022) which found a positive relationship between coping, self-efficacy, and MHSES. The findings highlighted dealing with MDD beyond medication through increasing autonomy to deal with challenges rather than being dependent on professional assistance and medication. Aligning with previous literature that medication is important in reducing symptoms, however, implementing change in daily occupations is vital to long-term recovery (Gopinath *et al.*, 2007). The participants were surprised by how many elements contributed to positive mental health through realising the contribution of their

destructive coping behaviours and mechanisms such as indecisiveness, lack of boundaries, control and ‘toxic traits’.

The symptoms of MDD reflect manifestations of self-inefficacy, such as low confidence and inability to manage challenges, leading to withdrawal from meaningful roles, and routines and disengagement from recovery efforts (Bandura, 1977; Taylor *et al.*, 2023). Therefore, promoting self-efficacy can assist in improving functional outcomes in MHCUs diagnosed with MDD. To go beyond the findings of improved self-efficacy after OTIGM intervention this section showcases how the OTIGM principles created a therapeutic environment which fostered opportunity for self-efficacy. Informed by the results from objective 4 which explored the perceived impact of the OTIGM intervention through the experienced principles and techniques which prompted the four sources of self-efficacy.

5.2.2. How the OTIGM fostered development Self-Efficacy

Occupational therapy group intervention differs from the verbal-based groups in Yalom and Leszcz (2005) psychological approach as it is activity-based (Davidson, 2018; Zedel & Chen, 2021). The OTIGM goes beyond learning in psychoeducation groups and participation in task-based groups as it includes discussion, illumination, experiential learning and reflection on activities and behaviour to generalise skills to their daily lives (Davidson 2018; Fouché 2021). The OTIGM serves to improve attitudes towards mental health and instil hope and belief towards the implementation of skills and behaviours to promote meaningful change, aligning with occupational therapy goals (AOTA, 2020; Taylor *et al.*, 2023). The presence of the key components from the OTIGM and Bandura (1977) 4 sources of self-efficacy 1) Mastery of Experiences, 2) Physiological and Emotional, 3) States Vicarious Experiences and 4) Verbal Persuasion are evident from the participants’ experiences.

In Table 4.6, which summarised how each source of self-efficacy was cultivated through the OTIGM intervention ‘group environment’ is noted under all four sources of self-efficacy, revealing it to be an underpinning element for the development of self-efficacy. The facilitator utilised group dynamics guided by Yalom’s curative factors (Fouché, 2021; Yalom & Leszcz, 2005). Including cohesion, instillation of hope, and universality which deepened interpersonal relationships amongst group members, described as a *“close*

family" -Emmett. Establishing a safe space cultivates opportunities for vulnerable emotional expression, allows for openness in sharing and receiving feedback, being their true selves and active engagement in activities. Enabling participants to confront and test perceptions, ultimately reducing defensive behaviours and reinforcing a sense of efficacy (Bandura, 1977). Supported by another study which highlighted that a safe group environment allowed MHCUs to practice social skills, positive relationships, acceptance and overall improved mental health (Radnitz *et al.*, 2019).

The safe space was initiated by the identification of collaborative group norms by participants. These are established during the forming and norming stages, aligning with curative factors to create a safe, non-judgmental environment that reduces anxiety and fosters trust (Yalom & Leszcz, 2005). Both participants in their first and subsequent admissions noted eagerness to return to the OTIGM group after the initial session and even expressed wanting more sessions after the intervention concluded, due to the curated safe space of the group environment. de Witt *et al.* (2021) identified that some MHCUs did not benefit from the therapeutic program during their first admission due to missed group opportunities and hesitant engagement stemming from fear, low self-efficacy, and lack of confidence. The closed-group nature of the OTIGM intervention addresses these challenges by fostering accountability for attendance and participation, thereby reducing missed treatment opportunities. Since the closed OTIGM intervention happens over four days, it naturally supports consistent group attendance, which is important in improving MHCUs' confidence in the application of skills learnt in groups (Radnitz *et al.*, 2019). Highlighting that occupational therapy closed groups may be more effective than open groups in improving activity participation, as they provide more time for exploration and foster stronger group cohesion (Meyer, 2020), *"But by the time [the group is over] you, you don't want to leave, you don't want it to end."* -Tabea. Therefore, the OTIGM principles promote continued and active engagement in the OTIGM, increasing the likelihood that MHCUs make progress while admitted as an in-patient.

The sense of safety participants experienced during the OTIGM intervention led them to believe in their capacity for personal growth and change, supporting Yalom & Leszcz (2005) who emphasised the importance of a safe group environment as the foundation for facilitating meaningful change. Therefore, the creation of a safe space in the OTIGM

intervention supports continued attendance, encourages change and serves as a basis for the development of self-efficacy.

5.2.2.1. Mastery of experiences

Occupational therapy literature highlights the core element of ‘doing’ within an individual’s occupational identity (Wilcock, 1999) which can be linked to mastery of experiences where individuals take action and perform tasks successfully. The OTIGM provides a structured, healthy external environment that fosters positive change in the internal system, shaping behaviour and beliefs about MHCUs ability to ‘do’ tasks (Kielhofner & Forsyth, 1997; Wilcock, 1998). The OTIGM makes use of experiential activities as a therapeutic medium where MHCUs actively practice new skills and complete tasks (AOTA, 2020; Fouché, 2021). Participants found a deeper sense of accomplishment by engaging directly in tasks rather than simply being told what to do. The experiential activities catalysed discussions allowing participants to gain new insights into their emotions and behaviours. Techniques such as illumination, activities, addressing emotions, and using symbolic exercises helped participants to externalise and confront their challenges. Therefore, creating opportunities to adjust their behaviour or apply appropriate skills in the ‘here and now’, created opportunities for real-time reflection and change as noted by Fouché (2014). Highlighting that engaging in activities is crucial for developing mastery, as the act of doing helps MHCUs build confidence and competence in their abilities.

Participants were surprised that the activities they engaged in held deeper meanings that, through reflective discussions, helped MHCUs to connect the activities to real-life challenges, *“playful games that will teach us something” -Sabina.* Emphasising the value of ‘fun’, participants noted that the activities uplifted their mood, allowed them to be energetic, and helped express their "inner child," providing a positive contrast to feelings of sadness and helplessness linked to MDD (APA, 2013). Furthermore, playfulness has been found to elicit emotions (also links to physiological and affective states) and improve learning opportunities, which encourages continued participation due to rewarding experience (Davidson, 2018; Ngooi *et al.*, 2021).

5.2.2.2. Physiological and Emotional States

The safe space of the group environment as previously mentioned played a vital role in creating a supportive environment allowing for vulnerability and genuine opportunities to explore affective physiological states. Physiological and Emotional States shaped self-efficacy as participants had the opportunity to learn and regulate their emotional responses to challenges related to MDD. The number of code occurrences of physiological and emotional states was approximately double (63) the other three sources of self-efficacy (29, 33, 34) as evident in Table 4.5 reflecting that this source of self-efficacy is possibly the most prominent in the OTIGM intervention. Since MDD is a mood disorder activating mood and developing emotional competence are key roles in developing self-efficacy for managing symptoms (APA, 2013).

The OTIGM intervention prompted emotional expression and regulation to shift difficult emotions to positive ones in the present moment (Fouché, 2021). Evident when the facilitator encouraged participants to take a reactive approach to their emotional responses through prompts and illumination, encouraging participants' sense of mastery within their ability to regulate their emotions. This aligns with Fouché (2021) who highlighted that success in conjunction with strong emotional experience increases the impact of lasting change. The OTIGM also promoted change in physiological and affective states through structured activities where participants experienced both confronted challenging emotions and fostering positive emotional states *"…it was a bit difficult to share my pain… I now know that sharing can help you heal."-Cecelia*.

The facilitator's client-centred and 'leading from behind' approach was particularly valuable because participants reported greater openness and engagement when themes were structured around their personal goals (Fouché, 2014; Kielhofner & Forsyth, 1997). Participants highlighted themes of forgiveness, social skills, perseverance, emotional regulation and emotional expression which were addressed in the group reinforcing their sense of resilience. Additionally, as highlighted by Fouché (2021) activities are selected to activate or relax participants' physiological state. Participants shared that the activities also provided a physical representation of their emotional burdens, allowing them to externalise and process their feelings. For example, participants reported that holding and releasing a balloon in an activity mirrored the act of carrying and letting go of long-held

stressors and negative emotions, creating a sense of relief and catharsis. Similarly, engaging with these symbolic tasks elicited dual emotional responses, where participants initially encountered stress or vulnerability but later reflected on feelings of relief, pride, and accomplishment.

Participants voiced hope and determined that the positive emotions and improved mood developed by the conclusion of the OTIGM would persist. However, a previous study highlighted hurdles of discharge readiness as unmet expectations, lack of social support and abrupt transition out of hospital, leading to reduced long-term application of health management (de Witt *et al.*, 2021; Mao *et al.*, 2024). Similar studies conducted by de Witt *et al.* (2021) and Ngooi *et al.* (2022), found mood to be a predictor of self-efficacy. Suggesting that if the MHCU's mood decreases on return home due to poor transition; their self-efficacy will also decrease. Although this paints a discouraging picture, Bandura (1977) highlights that past accomplishments and social comparison in a dependable environment allow individuals to shift away from perceived self-inefficacy. Therefore, by addressing real-life emotional challenges in a controlled environment utilising the 'feedback loop' by Kielhofner and Forsyth (1997), the OTIGM created opportunities for participants to process emotions, build resilience, contributing to their overall self-efficacy to *"start living" -Sabina*.

5.2.2.3. Vicarious experience

Vicarious experience is when participants observed group members perform tasks successfully and share coping strategies, reinforcing belief in their own abilities. Even prior to the start of the OTIGM intervention, vicarious experience played a role in participation in the therapeutic program, as seeing others eager to attend the group encouraged attendance. Peer modelling prompted group members to see one another's strengths and positive progress towards change, translating to personal belief for change abilities, highlighting observational learning within the OTIGM (Bandura, 1977; Fouché, 2021). Vicarious experience led to altruism, where participants celebrated each other's successes as if they were their own. Vicarious experience was noted to be more impactful when the person observed is perceived to be similar to oneself which was developed through the facilitation of universality and recapitulation of family group in this study (Yalom & Leszcz, 2005). Highting the value of social comparison which was cultivated

through discussions which encouraged participants to believe they can face their own challenges by recognising that their struggles are manageable *"So if somebody can let go of abuse, then I'm sure they can let go of people just gossiping about me."* - Tabea. Encouraging participants to confront their difficulties, strengthens the group's ability to manage emotional reactions collaboratively, transforming shared struggles into opportunities for skill development and personal achievement (Yalom & Leszcz, 2005). Therefore, linking vicarious experience to mastery as mirroring group member's vulnerability led to achieve more goals in the group as they are more engaged and open about their difficulties.

5.2.2.4. Verbal persuasion

Verbal persuasion led participants to believe they can successfully cope with challenges they previously found overwhelming through suggestions, advice or encouragement from other group members (Bandura, 1977). Additionally, facilitators modelled attentive, empowering, reassuring responses to group members providing constructive and positive feedback to reinforce their belief in their abilities. Verbal persuasion was also developed through challenging perceptions and behaviour through intervention strategies like constructive criticism and behaviour illumination (Fouché, 2021). These strategies further fostered self-reflection, emotional validation and recognition of personal strengths enabling individuals to shift their perspectives, build confidence and confront irrational thoughts. Additionally, the development of personal responsibility prompted participants to evaluate advice critically and take accountability for their own decisions. Bandura (1988) importantly highlights the interactive effect that encouragement alone can boost confidence in a task but when coupled with tools, strategies, guidance from a relatable peer and opportunity for mastery there is a lasting impact; which is highlighted by Sabina, *"[the facilitator] told me, and she said, 'Do it', and I did it. I think when you act on it, … you really absorb it… if you know it, go home and see how you do it."* -Sabina. Verbal persuasion seems to be pre-emptive to mastery as with encouragement the participant engaged in the task and thereafter reflected on success. Group members attributed universality, group norms and listening to one another to a sense of 'oneness'. Highlighting that relying on another is more valuable than being in *"silos"* - Nikita. Therefore, increasing

the credibility of the MOHO feedback loop as the support they received, promotes reinforcement and change (Kielhofner & Forsyth, 1997).

5.2.3. Development of self-agency

This study focused on how the OTIGM promotes self-efficacy, additionally, findings showed the growth of self-agency evident by a cultivated sense of independence, enabling participants to confront personal challenges. The findings highlighted participants' personal responsibility to themselves to take control in order to influence outcomes in their lives. While this study did not initially anticipate self-agency to emerge as a prominent finding, it is not surprising given that self-efficacy is one of the four core features of self-agency (Bandura *et al.*, 2001). Self-agency underscores the importance of believing in one's ability to succeed, which empowers individuals to take responsibility and actively shape their lives (Bandura, 1986).

> *"I am so much empowered …. it's my life at the end of the day. It is my life." - Nikita*

The other three core features of self-agency, *forethought*, *intentionality* and *self-reactiveness,* were also apparent in this study (Bandura, 2001; Code, 2020). The generalisation of outcomes from activities to discussions on practical application outside of the hospital relates to *forethought*. *Intentionality* was evident in the client-centred approach where participants set their own goals, and *self-reactiveness*, was identified in opportunities to regulate their behaviours in the 'here and now' (Fouché, 2021).

Self-agency emphasises the importance of taking responsibility and proactive action to address challenges, fostering autonomy and self-determination (Cole, 2018). The facilitator's guidance created a space for confrontation, where participants reflected on maladaptive patterns, identified areas of change and recognised their capacity to make decisions. The process of reflection allowed for the opportunity to reframe irrational thoughts, identify destructive coping mechanisms, and shift perspectives about conflicting social norms. Moreover, the focus on building practical skills and emotional regulation strategies, allowed participants to take responsibility for managing their mental health symptoms, as a decreased sense of responsibility has been found to lead to self-doubt in daily functioning (Taylor *et al.*, 2023). Ultimately, the OTIGM created a supportive

environment that empowered participants to embrace autonomy to make informed choices and take ownership of their personal growth and mental health (Fouché, 2021).

This study highlights the importance of active engagement and willingness for feedback in fostering self-efficacy within the OTIGM group. Contradicting the results from Ngooi *et al.* (2022), which indicated that participation did not have an impact on self-efficacy in occupational therapy task-based groups. Participants in this study observed that those who demonstrated active participation and genuine commitment to change achieved greater therapeutic gains than those who were resistant or hesitant. Consistent with seminal work by Kielhofner and Forsyth (1997), which reflected that meaningful group experiences were linked to increased confidence, proficiency, and self-assurance. These findings underscore the critical interplay between group dynamics and individual readiness in fostering self-efficacy. de Witt *et al.* (2021) noted that participants in their second admission were able to acknowledge responsibility for health compared to an external locus of control on the first admission. However, in this study, participants in their first admission already noted personal responsibility to *"apply my own thoughts and not always have to wait for being told what to do.*" -Miriam. It is not known what the therapeutic programme in the study by de Witt *et al.* (2021) included to objectively compare the type of interventions. Through the facilitation of autonomy, participants realised their ability to take control of their own problems, highlighting internal and external locus of control.

5.2.4.Preparedness for discharge

Discharge preparedness improved with duality after OTIGM intervention within the hospital environment (Table 4.7). Figure 4.4 indicates the change in the mean and standard deviation of discharge preparedness before and after is a statistically significant (p-value < 0.001). Although the data shows a significant overall improvement in discharge preparedness, a third of the quantitative sample reported no change or a decrease, suggesting that some participants did not feel more prepared for discharge, indicating that the OTIGM may have had limited impact on their readiness. The qualitative data also reflects ambivalence of improved readiness for discharge, evident in these two quotes *I'm ready to face the world" - Cecelia* and *"I am ready to be discharged, but I'm not ready to go back to work…" -Tabea.* The outlier identified in the quantitative sample (Figure 4.3) may reflect emotional dysregulation or disengagement in the group process, further

supporting the theme of ambivalence. Consistent with previous studies that found that mental health concerns often persist at discharge, particularly in chronic conditions like MDD where symptom severity influences recovery (de Witt *et al.*, 2021; Mao *et al.*, 2024). One participant, Nikita, had low MHSES (33) and discharge preparedness (1) ratings which was incongruent with her interview response that expressed a positive and hopeful outlook. Nikita's discrepancy in MHSES scores may be due to interview bias, social desirability bias like the Hawthrone effect or mood on the day of interview compared to when completing MHSES post-group questionnaire (Bispo Júnior, 2022; Sedgwick & Greenwood, 2015).

5.3. Effect of demographic factors of self-efficacy (Objective 2)

The second objective was to determine the effect of demographic factors on self-efficacy and discharge preparedness. Table 4.2 shows the demographic variables of age, race, gender, marital status, employment status, previous admission and number of days before discharge. Table 4.2 revealed age to be the only demographic variable to have a significant relationship with change in MHSES scores ($r = -0.26$, $p = 0.023$). A Singaporean study alternatively found a significant difference in post-test MHSES scores between gender and marital status where males and married individuals scored higher (Ngooi *et al.*, 2022). The difference in demographic relationships across the different studies may be due to cultural variability especially since self-efficacy is subjective (Cohen, 2001).

Age was found to have a weak negative correlation with change in MHSE after engaging in the OTIGM, suggesting that older participants experienced smaller increments of change compared to younger participants. No qualitative findings linked directly to age as noted in Table 4.9. Age variable can be explained by previous research indicated that emotional responsiveness and problem-solving as a coping skill tend to decline with age (Chen *et al.*, 2018). The OTIGM addresses these challenges by empowering participants through experiential learning and verbal persuasion to solve problems, stimulating physiological and affective states through activities. Therefore, the OTIGM potentially promotes healthy ageing, however, progress is expected to be less compared to younger MHCUs as explained by Erikson's (1998) life stages. As individuals shift from the 'middle age (40-65)' to 'old age (65+)' stage they shift from pursuing new goals to reflecting on

past achievements, which may lead to a decline in self-efficacy due to fewer opportunities for mastery experiences and reduced confidence in overcoming new challenges (Erikson, 1998).

Mood was noted to have a significant, weak positive correlation with the MHSES ($r = 0.27$, $p = 0.016$). The re-adjusted regression model in Table 4.3 indicated mood to be the only statistically significant variable ($\beta = 2.40$, p-value = 0.027). Reflecting that mood is a key predictor of MHSES scores mirroring findings by Ngooi *et al.* (2022) on task-based groups where mood and anxiety were significant predictors of coping self-efficacy. This study's findings indicated that the OTIGM intervention promoted physiological and emotional states, one of the sources of self-efficacy, suggesting that mood plays a central role in self-efficacy. Additionally, participants shared that their days were more enjoyable, as evidenced by the highest post-test MHSES rating (7.99) and feeling more positive (Table 4.8). The participants attributed their change in positivity to having gained skills to handle and notice symptoms; not necessarily noting a reduction in MDD symptoms. Therefore, supporting previous findings that higher self-efficacy levels empower individuals to handle negative challenges with resilience, whereas lower self-efficacy levels have the reverse effect, leaving participants feeling less capable of overcoming obstacles (Rabani *et al.*, 2011).

> *"I know that problems are still going to exist in the world. But if I've still got a roof over my head and my children are still breathing. Come on, like, life is good." -Tabea.*

Resilience is vital in the South African context, where the reintegration environment is shaped by complex challenges including financial strains, unemployment, limited access to continued healthcare, education and stigma of mental health; all of which are further compounded by the burden of mental health symptoms (Petersen & Lund, 2012; South African Department of Health, 2023). Stigma towards mental health is prevalent in South Africa, which is exacerbated by social exclusion and poverty (South African Department of Health, 2023). Participants noted that the stigma surrounding mental illness hindered their health-seeking behaviour, leading to further isolation and lower self-confidence (Magaard *et al.*, 2017; Yalom & Leszcz, 2005). While participants made progress in

shifting their personal, cultural, gendered and mental illness misconceptions; their fear of societal stigma when reintegrating into their workplace and community may limit their post-discharge outcomes (de Witt *et al.*, 2021). Especially in a private health setting where post-discharge services are limited to the MHCU's medical aid benefits (Meyer, 2020). Therefore, emphasising the importance of self-efficacy in mental health advocacy and education in continuity of care to promote a better transition to a home environment.

5.4. Relationship between Self-efficacy and Discharge Preparedness (Objective 3)

The third objective was to determine the relationship between self-efficacy and preparedness for discharge while exploring the duality of discharge preparedness through contrasting experiences, such as confidence and apprehension as evident in Table 4.9. Including the ambivalence of mixed feelings balancing both excitement and hesitation of carrying over newfound skills to daily life.

5.4.1. Discharge preparedness linked self-efficacy

The change in MHSES scores and discharge preparedness ratings have a monotonic relationship (Graph 4.5) and a weak positive significant correlation ($r = 0.306$, p-value = 0.006) as seen in Table 4.2. However, discharge preparedness was not noted to be a predictor variable of MHSES in the re-adjusted model ($\beta = 0.84$, $p = 0.051$);. Converging with qualitative perspectives which revealed how each source of self-efficacy impacted discharge readiness. Within 1) mastery of achievement and overcoming challenges such as social interaction, participants noted how they are applying skills of listening, being more patient and breathing techniques and believe they will be able to continue using them. 2) Carrying over their newfound positive mood and energy as well as learning skills to shift their physiological and affective states. 3) Vicarious experiences of observational learning and role modelling from others allowed for a shift in perspective and instilled hope in facing challenges on discharge. Lastly, participants noted that through 4) verbal persuasion gathered advice during the group allowing them to feel confident for when they will need to apply skills.

This study provides evidence that the OTIGM facilitates opportunities for success in performing skills to shift to positive emotional experience, therefore MHCUs can rely on

accomplishments from the group to possibly inform new situations once discharged. As highlighted in section 5.2.2.1, mastery is facilitated through 'doing' by actively engaging in new experiences and behaviour within the group, making it easier for implementation of new behaviours beyond the group. Consistent with prior research, changes made within the OTIGM intervention are likely to transfer to participants' homes, workplaces, and communities, supporting broader reintegration (Fouché, 2021). Participants indicated a perceived shift in both the internal and external subsystems described in the MOHO (Kielhofner & Forsyth, 1997) *"I project well outside, but I feel the relief inside, inner faith." -Muriel*. There is no significant difference in MHSES scores between participants with a previous psychiatric admission and participants in their index admission (p-value = 0.544). However, the findings show higher pre-test level of self-efficacy (Q1 = 3.50) among those with a prior admission compared to those in their index episode (Q1 = 0.00) possibly due to increased understanding of expectations (de Witt *et al.*, 2021).

5.4.2. Feelings of ambivalence in discharge preparedness

Participants noted their experience in the OTIGM was exemplified by the synergy of the hospital program. The OTIGM intervention worked alongside skills-based and psychoeducation groups in the hospital context by reinforcing skills learnt in other sessions. By creating a dynamic space where participants actively applied and mastered skills they learnt in the OTIGM intervention and other interventions. Beyond the OTIGM group, the structured hospital environment provided opportunities for participants to independently apply desired skills while socialising with other MHCUs. Participants noted opportunities to deal with the *"root core"* -Muriel in sessions with their psychologist. Highlighting the importance of a holistic approach to psychiatric interventions (AOTA, 2020). The routine facilitated by the daily milieu of the hospital promoted sleep hygiene, medication management, consistent mealtimes and social interaction, which is conducive to the functional occupational performance of ADLs and IADLs.

The perceived safety of the hospital environment played a crucial role in encouraging participants to experiment with new strategies and reflect on their progress. The controlled setting enabled participants to feel secure while engaging in self-discovery and testing their limits. Participants practised applying skills to real-life interactions with people outside the hospital (phone calls and/or visitors) such as demonstrating patience and

practising effective communication and boundary-setting. While the hospital was positively described as safe, it was also described as a confined space for participants to practice coping mechanisms without external pressures, therefore possibly overprotecting MHCUs, limiting the transition of these skills. One participant even noted not wanting to return home due to the experience of safety in the hospital. The participants perceived their home and societal environments as more challenging and less predictable due to fear of social exclusion and stigma hindering their perceived generalisation of skills (South African Department of Health, 2023). The contrast between the hospital and home environments underscores the importance of empowering MHCUs to internalise their progress and build self-agency, enabling them to navigate the complexities of life beyond the hospital and to provide appropriate discharge support. Psychiatric day hospitals may be beneficial to address the application of skills to the home environment. However limited literature was found, a recent scoping review on occupational literature in day hospitals highlighted the ambiguity of occupational therapy services in this setting and did not overtly mention the OTIGM (Masango *et al.*, 2024).

5.4.2.1. Areas of Occupation

The OTIGM intervention prepared MHCUs for discharge by fostering self-efficacy that directly enhanced their performance across key areas of life. Before admission, participants described occupational deprivation within social interactions, work roles, and daily functioning, aligning with the pervasive impairment that is characteristic of MDD (AOTA, 2020; APA, 2013). After OTIGM intervention participants highlighted a positive shift in their internal subsystem including volition, roles and routines, and performance and improved skills and application as participants noted being more eager to regain occupations (Kielhofner & Forsyth, 1997). *“Managing your depression, I just thought I had to get over it. I didn’t know that it’s one step at a time, one day at a time …I want to join a gym, I want to, I want to live healthier...” -Tabea.* Participants reported improvements in health management, leisure engagement, sleep hygiene and most notably, social participation. These gains reflect the intervention’s focus on equipping individuals to reintegrate into meaningful roles and responsibilities, aligning with previous research emphasising the role of self-efficacy in functional recovery (Kelly *et al.*, 2010). Participants expressed increased confidence in forming and maintaining relationships, both within and

outside the hospital setting. Corresponding with previous research on the value of group therapy which creates a supportive environment to build social connections and reduce isolation (Cole, 2018) and improves interpersonal learning and relationship strengthening (Radnitz *et al.*, 2019). The interactive nature of the OTIGM focuses on the premise that interpersonal skills and social support are critical to improving the quality of life and reducing the risk of relapse in mental health conditions like MDD (de Witt *et al.*, 2021; Fouché, 2021). While some participants felt empowered about succeeding in their occupations post-discharge, others expressed concerns about sustaining this progress outside the structured and supportive environment of the hospital. Highlighting the need for comprehensive discharge planning, including community referrals and strategies to bridge the gap between the hospital and real-world contexts, addressing potential occupational deprivation and fostering long-term independence (Donisi *et al.*, 2016; Petersen & Lund, 2012). Illuminating the OTIGM's approach to address occupational deprivation and equip participants in both immediate recovery and long-term resilience with the tools for meaningful engagement post-discharge.

5.4.2.2. Future planning

Participants highlighted their perceived optimism and determination to sustain the progress made in the hospital, however, some participants exhibited unrealistic expectations regarding their ability to avoid relapse entirely, suggesting overconfidence that could lead to challenges if setbacks occur. This is consistent with research indicating that high self-efficacy may result in overconfidence and potentially increase the likelihood of errors (Vancouver *et al.*, 2002). Participants noted increased awareness of their mental health and risks of relapse and expressed confidence in their ability to recognise early warning signs and take proactive steps to mitigate them. However, de Witt *et al.* (2021) warn that unanticipated difficulties and unmet expectations after discharge are indicators of relapse. Despite these concerns, participants also acknowledged the importance of self-compassion, expressing a willingness to adapt and try again when encountering difficulties. This balance between optimism and realism underscores the importance of accommodating the complexities of recovery within the acute hospital model, as well as supporting the need for continued support in skill application post-discharge since MDD is a chronic condition. It is not expected that all symptoms will be resolved by discharge,

meaning that there may still be residual difficulties post-discharge (AOTA, 2020; de Witt *et al.*, 2021).

the 2002 Mental Health Care Act No.17 (South Africa, 2002) which promotes a focus on rehabilitative and community-based care; the NHI (South Africa, 2024) aims to bridge this gap in continued care for MHCUs (Evans-Lacko *et al.*, 2018). Furthermore, addressing the 'revolving door phenomenon' to ultimately reduce the need for readmissions (Mao *et al.*, 2024; Petersen & Lund, 2012). However, participants voiced feelings of lack of control and stress expressed by participants in this study over the discharge process, specifically not knowing when they will be discharged due to medical aid funding. Echoing the study by de Witt *et al.* (2021), based on a similar psychiatric context, highlighted that the length of admission was limited by their medical aid coverage rather than the achievement of their treatment goals (Silaule, 2016). Additionally, the medical aid prescribed minimum benefits focus on in-patient care and MHCUs need to independently fund the high cost of effective, holistic, and appropriate MDT out-patient services to promote reintegration (Mahaffey *et al.*, 2015). Therefore, it is important to make the greatest impact on intervention while MHCUs are admitted as an inpatient and empower MHCUs in the application of progress to their community environment (Ramano, 2017). A study by Oedegaard *et al.* (2020) highlighted that involving MHCUs in treatment planning enhances self-agency, while Mao *et al.* (2024) emphasised the benefits of personalised discharge planning in improving post-discharge outcomes. This highlights the importance of fostering self-efficacy and self-agency during admission to ultimately reduce relapses and readmission.

5.5. Conclusion

The results of this study rejected the null hypothesis of quantitative objectives one, two and three. The results found that the OTIGM improved self-efficacy; self-efficacy correlates with mood and age; and higher self-efficacy scores resulted in higher discharge preparedness ratings evident by a positive correlation within an acute, private psychiatric hospital. The quantitative objectives were complimented by the qualitative findings of objective four which reflected on the participant's perceived impact of the OTIGM intervention on their self-efficacy and discharge preparedness The joint displays of

quantitative results with qualitative findings highlight the convergence of the two data strands and overall address all four objectives.

The OTIGM improves discharge preparedness by fostering self-efficacy and self-agency through experiential learning and social interaction within a safe space, empowering MHCUs' independence in their recovery of MDD symptoms through successfully implementing the gains from OTIGM intervention. The discussion has shown how this study supports the theoretical frameworks and previous studies on self-efficacy which highlighted how self-efficacy positively correlates with mental health recovery. The reality of ambivalence in readiness for discharge and future application found similarities with literature on the challenges of functional recovery in the acute, short stay settings in the South African context. The research highlighted the benefits of the interactive approach on self-efficacy, with the most notable impacts on occupational functioning, social participation, and mood, enhanced by the synergy of the therapeutic program

CHAPTER 6: CONCLUSION

6.1. Introduction

The aim of the study was to explore the development of self-efficacy and discharge preparedness in MHCUs with Major Depressive Disorder (MDD) after Occupational Therapy Interactive Group model (OTIGM) at a private acute psychiatric setting in South Africa, using a parallel convergent mixed methods study. The limitations of the study, implications, future recommendations and value contribution are presented in this chapter, closing with the final conclusion of this research dissertation.

6.2. Summary

The main findings of this study identified the convergence of quantitative and qualitative strands to reflect on the development of all four sources of self-efficacy (mastery of experiences, physiological and affective states, vicarious experience and verbal persuasion) leading to positive albeit hesitant shift towards the reality of preparing for discharge; after MHCUs with MDD engaged in the closed OTIGM group intervention over four days. This study showed the findings from the OTIGM group intervention underscored by Fouché (2021), Bandura (1977), and (Kielhofner & Forsyth, 1997) improvement in self-efficacy and discharge preparedness. Key contributors towards change emerging from the OTIGM group intervention included the benefits of experiential learning through activities, the safe space created by group dynamics and positive shift in emotional state. Self-agency was also fostered during the intervention leading to improved perceived responsibility to mental health and occupational functioning beyond discharge, specifically social participation. Additionally, the synergy between the structured group process and the protected hospital environment was found to play a significant role in supporting therapeutic engagement and readiness for transition to MHCUs home context. The mixed methods design allowed for a deeper understanding of both the measurable improvement in MHSES scores and the subjective experiences underlying those changes, reinforcing the clinical value of OTIGM in psychiatric group therapy.

6.3. Limitations

This study did not make use of a control group to compare the change in self-efficacy based on the hospital programme with and without the OTIGM, due to the structure of the

hospital's existing programme it was not feasible and misaligns with the ethical principle of beneficence. However, the qualitative data provided evidence and support of improved self-efficacy and highlighted the contribution of the synergy of the hospital environment. Due to the logistical constraints, the study did not include post-discharge data, which would have provided insights into the longer-term impact of the OTIGM on discharge preparedness. Another limitation was the lack of inclusion of MHCUs with previous admissions, which would have provided valuable insights into post-discharge reintegration and long-term impact of the intervention, as the results indicated that there was no difference in MHSES in their index admission versus a follow-up admission. The inclusion criteria for MDD was based on admission diagnosis and the MHCUs' diagnosis which may have changed by the onset of their attendance of the OTIGM intervention.

Since the qualitative study included deductive, pre-determined codes it may have influenced the probing questions and general prompts identified in the interview guide and during the interview highlighting a possible bias. Due to the subjective nature of self-efficacy, bias and reliability may be affected. Additionally, the MHSES tool, is a self-report measure providing an outcome measure view of subjective construct. Therefore including an objective evaluation of group engagement by the facilitator or assessment tool may have provided another perspective. Furthermore, participant responses may have been influenced by social desirability bias or the Hawthorne effect, altering their responses to align with their perception of the researcher expectations therefore focusing more on positive reports rather than critically evaluating their experience of the OTIGM group intervention (Sedgwick & Greenwood, 2015).

Furthermore, mood was found to be a predictor of MHSES therefore that participants' varying moods, such as MDD as a mood disorder, could lead to varying responses dependent on their mood at the time of completing forms or participating in interviews. Regarding data analysis of interviews, it was noted that participants' use of colloquialisms or limited articulation of their experience may have hindered a deeper understanding of their experiences and impacted the clarity or meaning pulled from their responses. Additionally, all interviews were conducted in English which may not be the participant's home language; thus there may have been limitations in their ability to fully express themselves, possibly impacting the depth and nuance of their contributions to the study.

6.4. Implications

6.4.1. Outcome based measure

The introduction of National Health Insurance (NHI) in South Africa emphasises the need for evidence-based occupational therapy interventions to reduce healthcare inequalities (Myezwa & Van Niekerk, 2013; OTASA, 2021). Since many symptoms of MDD and mental illness are subjective in nature, self-report methods are appropriate (Bandura, 2006). The MHSES is a quick, subjective test which can be done outside of the group times and does not require hands-on time from the facilitator. The discharge preparedness and mood rating scales were simple Likert scales which also provided quantitative, subjective evidence of change. This may encourage the use of the MHSES as an outcome-based measure to collect evidence for discharge readiness. This study provides evidence of the improvement in self-efficacy and discharge readiness as a result of the OTIGM intervention, supporting the efficacy of in-hospital occupational therapy services. Producing evidence-based research by using tools such as the MHSES is important in advocating for occupational therapy services, especially due to the implementation of the National Health Insurance bill that was signed in 2024 (South Africa, 2023). Additionally, the change in ratings may also be used as a reflective opportunity in treatment so MHCUs can objectively track their progress.

6.4.2. Promotion of OTIGM in practice

Previous research has identified self-efficacy as an indicator of positive mental health, and this study highlights its positive correlation with mood, demonstrating its value in tracking and treating mood disorders such as MDD. The OTIGM promotes all four sources of self-efficacy and self-agency which were found to support continuation of care and heightened personal responsibility to mental health promotion in MHCUs diagnosed with MDD. Furthermore, this study highlights the synergistic value of the therapeutic program, emphasising that the OTIGM does not work in isolation and that all interventions, including the hospital's daily milieu, contribute to holistic and optimised treatment during acute short-stay psychiatric admissions.

This research may also encourage occupational therapists to train in OTIGM and advocate for OTIGM group intervention in their hospital settings and to make use of

prompting the four sources of self-efficacy. Although this study found these are naturally occurring in the OTIGM, it may be beneficial to be mindful thereof when facilitating groups. This research also serves as a reminder to occupational therapists working in the acute setting to incorporate discharge elements during treatment with a view to: 1) optimise in-patient treatment and 2) focus on out-referring to NGOs and support groups. Strengthening relationships in the MDT to best support MHCUs after discharge despite not being able to access occupational therapy services as an out-patient.

6.5. Recommendations

- Recommendations for future research

Future research could benefit from including a longitudinal follow-up to assess the sustained impact of the OTIGM intervention and track self-efficacy over the discharge and community reintegration process. While previous research has indicated a positive relationship between self-efficacy and mental health, it could be valuable to explore the MHSES relationship with occupational performance, possibly using the APOM. The daily milieu of the hospital was noted to be an important contributor, and since occupational therapists are experts in occupations, research can explore how to further optimise MHCUs' daily routines and habits to promote occupational balance and performance. Given the subjective nature of self-efficacy, it may be valuable to explore the variance of self-efficacy across different cultures and/or contexts.

- Recommendations for practice

To explore the use of the OTIGM in day programs where MHCUs can apply skills or test behaviours explored in the group each day, even exploring opportunities for short-term exits from the hospital to slowly reintegrate during an admission period. To provide feedback to the hospital research site to enhance patient care and discharge planning strategies. Especially due to the impact of the hospital environment, it is important for psychiatric hospitals to promote balanced and healthy routines with a holistic approach to support all areas of occupation. To further advocate for occupational therapy services and its unique contribution to addressing self-efficacy and self-agency in MHCUs overcoming MDD symptoms using both quantitative and qualitative evidence.

- Recommendations for occupational therapy education

The study will also be available to the Faculty of Health Sciences via the University of the Witwatersrand databases to aid future researchers on themes of self-efficacy within group therapy and preparing MHCUs for discharge at a private psychiatric hospital, especially in the treatment of MDD as OTIGM promotes social interaction and stimulates mood more so than individual therapy. The theoretical frameworks highlighted that the four sources of self-efficacy and self-agency are occurring in both MOHO (Kielhofner & Forsyth, 1997) and OTIGM (Fouché, 2021) therefore bringing awareness to assessment and treatment in order to improve treatment outcomes. Highlight their value in group therapy interventions to increase the probability of long-term application of skills post-discharge since occupational therapy intervention is not always continued post-discharge.

6.6. Conclusion and Value Contribution

In conclusion, this study demonstrates that the OTIGM is an effective intervention for MHCUs diagnosed with MDD to assist in developing mental health self-efficacy to empower MHCUs to be better prepared to face challenges when returning home from an acute psychiatric setting in South Africa. Supported by a parallel convergent mixed methods study integrating quantitative evidence using the MHSES tool and qualitative perspective findings. The findings align with Bandura's (1977) Social Learning Theory, indicating that the OTIGM promoted the four sources of self-efficacy: mastery of experiences, vicarious experiences, verbal persuasion, and physiological and emotional States. Enabling MHCUs with MDD to build self-confidence and develop skills to manage their mental health challenges more effectively. Aligning with previous research, which identified self-efficacy to be a key contributor to mental health recovery and improved well-being.

The safe space fostered in the closed OTIGM group intervention over four days allowed for strong group dynamics, creating the conditions for enhancing self-efficacy and self-agency leading to meaningful change. Therefore. The closed-group format proved to be effective in encouraging ongoing participation and progress as the group structure offered a stable, supportive environment. Additionally, the OTIGM provided participants with a greater sense of agency, enabling them to take responsibility for their mental health well-

being and occupational engagement. The combination of self-efficacy and self-agency observed in this study underscored the importance of empowering MHCUs to actively participate in their recovery and take proactive steps toward reintegration into their communities.

The participants' experienced renewed hope and emotional resilience which assisted in implementing skills while admitted in the hospital environment. However, the findings also revealed significant challenges, including participants' concerns about applying newly acquired skills in less controlled and more socially stigmatising environments beyond the hospital. Indicating MHCUs feelings of ambivalence reflecting both hope and hesitancy towards discharge preparedness. While participants positively expressed their commitment to applying gains from OTIGM intervention after discharge; unrealistic expectations about entirely avoiding relapse were noted. Highlighting the need for realistic goal setting, ongoing post-discharge support, and addressing stigma to sustain the benefits of the OTIGM group intervention. Highlighting that closed OTIGM group invention empowers MHCUs self-efficacy and promotes occupational engagement and discharge readiness may allow for a greater success post-discharge from a private, acute psychiatric hospital.

Overall, this study underscores the potential of the OTIGM intervention to bridge the gap between acute care and community reintegration, demonstrating its value in promoting self-efficacy and discharge preparedness by empowering MHCUs to manage their mental health with greater autonomy. This study provides evidence supporting OTIGM as an effective practice in treating MHCUs with MDD. Ulitmalty this research contributes to practice- and evidence-based occupational therapy interventions, supporting their role in addressing mental health challenges and advocating for more accessible, appropriate care within the transition towards the NHI in the South African healthcare context.

REFERENCES

American Occupational Therapy Association (AOTA). (2014). Occupational Therapy Practice Framework: Domain and Process (3rd ed.). *In American Journal of Occupational Therapy, 68*, 1-48. https://doi.org/10.5014/ajot.2014.682006

American Occupational Therapy Association (AOTA). (2020). Occupational therapy practice framework: Domain and process (4th ed.). *In American Journal of Occupational Therapy 74*(4), 1-87. American Occupational Therapy Association, Inc. https://doi.org/10.5014/ajot.2020.74S2001

American Psychiatric Association (APA). (2013). Diagnostic and Statistical Manual of Mental Disorders (5th ed.). In New York American Psychiatric Press Inc. American Psychiatric Publishing, Inc. https://doi.org/10.1176/appi.books.9780890425596.893619

Bandura, A. (1977). Self-efficacy: Toward a unifying theory of behavioral change. *Psychological Review*, *84*(2), 191-215. https://doi.org/10.1037/0033-295X.84.2.191

Bandura, A. (1986). Social foundations of thought and action: A social cognitive theory. In *Social foundations of thought and action: A social cognitive theory.* Prentice-Hall, Inc.

Bandura, A. (1988). Self-efficacy conception of anxiety. *Anxiety Research*, *1*(2), 77-98. https://doi.org/10.1080/10615808808248222

Bandura, A. (2001). Social Cognitive Theory: An Agentic Perspective. *Annual Review of Psychology*, *52*(1), 1-26. https://doi.org/10.1146/annurev.psych.52.1.1

Bandura, A. (2006). Guide for constructing self-efficacy scales. *Self-Efficacy Beliefs of Adolescents*. https://doi.org/10.1017/CBO9781107415324.004

Bandura, A., Barbaranelli, C., Caprara, G. V, & Pastorelli, C. (2001). Self-efficacy beliefs as shapers of children's aspirations and career trajectories. *Child Development*, *72*(1), 187-206. https://doi.org/10.1111/1467-8624.00273

Benatti, B., Girone, N., Conti, D., Cocchi, M., Achilli, F., Leo, S., Putti, G., Bosi, M., & Dell'Osso, B. (2023). The Role of Lifestyle on Adherence to Treatment in a Sample of

Patients with Unipolar and Bipolar Depression. *International Journal of Environmental Research and Public Health*, *20*(3), 1994. https://doi.org/10.3390/ijerph20031994

Bispo Júnior, J. P. (2022). Social desirability bias in qualitative health research. *Revista de Saúde Pública*, *56*, 101. https://doi.org/10.11606/s1518-8787.2022056004164

Bradshaw, C., Atkinson, S., & Doody, O. (2017). Employing a Qualitative Description Approach in Health Care Research. *Global Qualitative Nursing Research*, *4*, 233339361774228. https://doi.org/10.1177/2333393617742282

Burns, J. K. (2008). Implementation of the Mental Health Care Act (2002) at district hospitals in South Africa: Translating principles into practice. *South African Medical Journal*, *98*(1), 46-49.

Casteleijn, D. (2010). *Development of an outcome measure for occupational therapists in mental health care settings*. https://repository.up.ac.za/handle/2263/28019

Casteleijn, D. (2013). Stepping Stones from Input to Outcomes : An Occupational Perspective. *South African Journal of Occupational Therapy*. *43*(1), 1-9.

Chen, Y., Peng, Y., Xu, H., & O'Brien, W. H. (2018). Age Differences in Stress and Coping: Problem-Focused Strategies Mediate the Relationship Between Age and Positive Affect. *The International Journal of Aging and Human Development*, *86*(4), 347-363. https://doi.org/10.1177/0091415017720890

Clarke, J., Proudfoot, J., Birch, M. R., Whitton, A. E., Parker, G., Manicavasagar, V., Harrison, V., Christensen, H., & Hadzi-Pavlovic, D. (2014). Effects of Mental Health Self-Efficacy on Outcomes of a Mobile Phone and Web Intervention for Mild-to-Moderate Depression, Anxiety and Stress: Secondary Analysis of a Randomised Controlled Trial. *BMC Psychiatry*, *14*(1), 1-10. https://doi.org/10.1186/s12888-014-0272-1

Code, J. (2020). Agency for Learning: Intention, Motivation, Self-Efficacy and Self-Regulation. *Frontiers in Education*, *5*. https://doi.org/10.3389/feduc.2020.00019

Cohen, D. (2001). Cultural variation: Considerations and implications. *Psychological Bulletin*, *127*(4), 451-471. https://doi.org/10.1037/0033-2909.127.4.451

Cole, M. B. (2018). *Group Dynamics in Occupational Therapy the Theoretical Basis and Practice Application of Group Intervention* (5th ed.). SLACK Incorporated.

Craig, A., Rochat, T., Naicker, S. N., Mapanga, W., Mtintsilana, A., Dlamini, S. N., Ware, L. J., Du Toit, J., Draper, C. E., Richter, L., & Norris, S. A. (2022). The Prevalence of Probable Depression and Probable Anxiety, and Associations with Adverse Childhood Experiences and Socio-Demographics: A National Survey in South Africa. *Frontiers in Public Health*, *10*. https://doi.org/10.3389/fpubh.2022.986531

Creswell, J. (2015). *A Concise Introduction to Mixed Methods Research*. Sage Publications.

Creswell, J., & Clark, V. (2017). *Designing and Conducting Mixed Methods Research* (3rd ed.). SAGE Publications, Inc.

Creswell, J., & Creswell, D. (2018). *Research Design: Qualitative, Quantitative, and Mixed Methods Approaches* (5th ed.). Sage.

Crouch, R. (2021). *Occupational Group Therapy*. John Wiley & Sons Ltd.

Cuthbertson, L. M., Robb, Y. A., & Blair, S. (2020). Theory and application of research principles and philosophical underpinning for a study utilising interpretative phenomenological analysis. *Radiography*, *26*(2), e94-e102. https://doi.org/10.1016/j.radi.2019.11.092

Davidson, S. (2018). *Perceptions of Mental Health Care Users on the Contribution of the Interactive Groupwork Model in Occupational Therapy Groups to Their Recovery*. http://library.wur.nl/WebQuery/wurpubs/fulltext/353506

De Vos, A., Strydom, H., Fouche, C., & Delport, C. (2011). *Research at Grass Roots: For Social Sciences and Human Services Professions*. Van Schaik Publishers.

de Witt, P. (2014). Creative ability: A model for individual and group occupational therapy for clients with psychosocial dysfunction. *Occupational Therapy in Psychiatry and Mental Health* (5th ed.).

de Witt, P., Roestorff-Hambrock, N., Adams, F., & Franzsen, D. (2021). Challenges impacting functional recovery experienced by Mental Health Care Users with Major Depressive Disorder after a short-term admission to hospital. *South African Journal of Occupational Therapy*, *51*(2), 55-64. https://doi.org/10.17159/2310-3833/2021/vol51n2a8

Discovery Health Medical Scheme. (2024). *What is Medical Aid?* https://www.discovery.co.za/medical-aid/

Donisi, V., Tedeschi, F., Wahlbeck, K., Haaramo, P., & Amaddeo, F. (2016). Pre-discharge factors predicting readmissions of psychiatric patients: a systematic review of the literature. *BMC Psychiatry*, *16*, 1-17. https://doi.org/10.1186/s12888-016-1114-0

Erikson, E. H. (1998). The life cycle completed (extended version). WW Norton & Company.

Evans-Lacko, S., Aguilar-Gaxiola, S., Al-Hamzawi, A., Alonso, J., Benjet, C., Bruffaerts, R., Chiu, W. T., Florescu, S., de Girolamo, G., Gureje, O., Haro, J. M., He, Y., Hu, C., Karam, E. G., Kawakami, N., Lee, S., Lund, C., Kovess-Masfety, V., Levinson, D., … & Thornicroft, G. (2018). Socio-Economic Variations in the Mental Health Treatment Gap for People with Anxiety, Mood, and Substance Use Disorders: Results from the WHO World Mental Health (WMH) surveys. *Psychological Medicine*, *48*(9), 1560-1571. https://doi.org/10.1017/S0033291717003336

Flick, U. (2018). *The SAGE Handbook of Qualitative Data Collection*. SAGE Publications Ltd. https://doi.org/10.4135/9781526416070

Fouché, L. (2014). *Experiential workshop in occupational group therapy: Core Concepts of the Interactive Occupational Therapy Group Model*. Unpublished OT Grow workshop notes on the Interactive Groupwork Model.

Fouché, L. (2021). The Occupational Therapy Interactive Group Model (OTIGM). In *Occupational Group Therapy* (21-64). Wiley. https://doi.org/10.1002/9781119591498.ch4

Gage, M., Noh, S., Polatajko, H. J., & Kaspar, V. (1994). Measuring Perceived Self-Efficacy in Occupational Therapy. *The American Journal of Occupational Therapy*, *48*(9), 783-790. https://doi.org/10.5014/ajot.48.9.783

Gillham, B. (2000). *The Research Interview*. Continuum.

Gopinath, S., Katon, W. J., Russo, J. E., & Ludman, E. J. (2007). Clinical Factors Associated with Relapse in Primary Care Patients with Chronic or Recurrent Depression. *Journal of Affective Disorders*, *101*(1-3), 57-63. https://doi.org/10.1016/j.jad.2006.10.023

Guest, G., Bunce, A., & Johnson, L. (2006). How Many Interviews are Enough? *Field Methods*, *18*(1), 59–82. https://doi.org/10.1177/1525822X05279903

Hegedüs, A., Kozel, B., Richter, D., & Behrens, J. (2020). Effectiveness of Transitional Interventions in Improving Patient Outcomes and Service Use After Discharge from Psychiatric Inpatient Care: A Systematic Review and Meta-Analysis. In *Frontiers in Psychiatry, 10*, 969. Frontiers Media S.A. https://doi.org/10.3389/fpsyt.2019.00969

Hitch, D., Pépin, G., & Stagnitti, K. (2014). In the Footsteps of Wilcock, Part Two: The Interdependent Nature of Doing, Being, Becoming, and Belonging. *Occupational Therapy in Health Care*, *28*(3), 247-263. https://doi.org/10.3109/07380577.2014.898115

Hsieh, H. F., & Shannon, S. E. (2005). Three Approaches to Qualitative Content Analysis. *Qualitative Health Research*, *15*(9), 1277-1288. https://doi.org/10.1177/1049732305276687

Johnson, R. B., Onwuegbuzie, A. J., & Turner, L. A. (2007). Toward a Definition of Mixed Methods Research. *Journal of Mixed Methods Research*, *1*(2), 112-133. https://doi.org/10.1177/1558689806298224

Kelly, M., Lamont, S., & Brunero, S. (2010). An Occupational Perspective of the Recovery Journey in Mental Health. *British Journal of Occupational Therapy*, *73*(3), 129-135. https://doi.org/10.4276/030802210X12682330090532

Khalifeh, A. H., Alhalaiqa, F. N., Hamaideh, S. H., Horne, R., & Hamdan-Mansour, A. M. (2023). The Effect of Adherence Therapy on Medication Adherence, Health Beliefs, Self-

Efficacy, and Depressive Symptoms Among Patients Diagnosed with Major Depressive Disorder. *International Journal of Mental Health Nursing*, *32*(3), 778-790. https://doi.org/10.1111/inm.13113

Kielhofner, G., & Forsyth, K. (1997). The Model of Human Occupation: An Overview of Current Concepts. *British Journal of Occupational Therapy,60*(3), 103-110.

Korstjens, I., & Moser, A. (2018). Series: Practical guidance to qualitative research. Part 4: Trustworthiness and publishing. *European Journal of General Practice*, *24*(1), 120-124. https://doi.org/10.1080/13814788.2017.1375092

Krefting, L. (1991). Rigor in Qualitative Research: The Assessment of Trustworthiness. *The American Journal of Occupational Therapy*, *45*(3), 214-222. https://doi.org/10.5014/ajot.45.3.214

Kruger, M., Ndebele, P., & Horn, L. (2014). *Research ethics in Africa.* Sun Press.

Laird, K. T., Krause, B., Funes, C., & Lavretsky, H. (2019). Psychobiological factors of resilience and depression in late life. *Translational Psychiatry*, *9*(1), 88. https://doi.org/10.1038/s41398-019-0424-7

Leedy, P., & Ormrod, J. (2010). *Practical Research* (9th ed.). Pearson.

Magaard, J. L., Seeralan, T., Schulz, H., & Brütt, A. L. (2017). Factors Associated with Help-Seeking Behaviour Among Individuals with Major Depression: A Systematic Review. *PLoS one*, *12*(5), e0176730. https://doi.org/10.1371/journal.pone.0176730

Mahaffey, L., Burson, K. A., Januszewski, C., Pitts, D. B., & Preissner, K. (2015). Role for Occupational Therapy in Community Mental Health: Using Policy to Advance Scholarship of Practice. *Occupational Therapy in Health Care*, *29*(4), 397-410. https://doi.org/10.3109/07380577.2015.1051689

Mao, W., Shalaby, R., Owusu, E., Elgendy, H. E., Agyapong, B., Eboreime, E., Silverstone, P., Chue, P., Li, X.-M., Vuong, W., Ohinmaa, A., Taylor, V., Greenshaw, A. J., & Agyapong, V. I. O. (2024). Depression, anxiety, and poor well-being at discharge

from psychiatric hospitals: prevalence and risk factors. *Frontiers in Psychiatry*, *15*. https://doi.org/10.3389/fpsyt.2024.1408095

Marshall, C. A., Murphy, M., Marchiori, K., Aryobi, S., Wener, P., White, C., Larivière, N., Isard, R., Chohan, A., Forhan, M., Kiepek, N., Barbic, S., Sarunsky, V., & Moll, S. (2022). Psychotherapy Within Occupational Therapy Literature: A Scoping Review. *Canadian Journal of Occupational Therapy*, *89*(4), 376-394. https://doi.org/10.1177/00084174221102732

Masango, J., Casteleijn, D., Adams, F., & van der Merwe, T. R. (2024). Occupational Therapy Practice in Psychiatric Day Hospitals: A Scoping Review. *South African Journal of Occupational Therapy*, *54*(3), 1-11. https://doi.org/10.17159/2310-3833/2024/vol54no3a5

Meyer, A. F. (2020). *Change in Activity Participation of Mental Health Care* (Masters thesis). University of Witwatersrand, Johannesburg.

Morgan, D. L. (2007). Paradigms Lost and Pragmatism Regained. *Journal of Mixed Methods Research*, *1*(1), 48-76. https://doi.org/10.1177/2345678906292462

Myezwa, H., & Van Niekerk, M. (2013). National Health Insurance implications for Rehabilitation Professionals and Service Delivery. *South African Journal of Physiotherapy*, *69*(4), 3-9. https://doi.org/10.4102/sajp.v69i4.372

Ngooi, B. X., Wong, S. R., Chen, J. D., Koh, V. S. Y., Ng, A. R. W., Sahrol, S. B., Lai, J. K. W., Lim, J. C. S., Fong, N. C. E., & Tan, W. R. (2021). Benefits of Occupational Therapy Activity-Based Groups in a Singapore Acute Psychiatric Ward: Participants' Perspectives. *Occupational Therapy in Mental Health*, *37*(1), 38-55. https://doi.org/10.1080/0164212X.2021.1874591

Ngooi, B. X., Wong, S. R., Chen, J. D., & Yin Koh, V. S. (2022). Exploring the use of activity-based group therapy in increasing self-efficacy and subjective well-being in acute mental health. *Hong Kong Journal of Occupational Therapy*, *35*(1), 52-61. https://doi.org/10.1177/15691861221075798

Ober, J. L., Newbury, R. S., & Lape, J. E. (2022). The Dynamic Use of the Kawa Model: A Scoping Review. The Open Journal of Occupational Therapy, *10*(2), 1-12. https://doi.org/10.15453/2168-6408.1952

Oedegaard, C. H., Davidson, L., Stige, B., Veseth, M., Blindheim, A., Garvik, L., Sørensen, J.-M., Søraa, Ø., & Engebretsen, I. M. S. (2020). “It means so much for me to have a choice”: a qualitative study providing first-person perspectives on medication-free treatment in mental health care. *BMC Psychiatry*, *20*(1), 399. https://doi.org/10.1186/s12888-020-02770-2

OT Grow. (2022). *Welcome to OT Grow*. https://otgrow.co.za

Occupational Therapy Association of South Africa (OTASA). (2019). *OTASA Annual Report 2018-2019*. https://www.otasa.org.za/wp-content/uploads/2021/11/Annual-Report-2018-2019.pdf

Occupational Therapy Association of South Africa (OTASA). (2021). *OTASA Annual Report 2020-2021*. https://www.otasa.org.za/wp-content/uploads/2021/11/Annual-Report-2020-2021.pdf

Palinkas, L. A., Horwitz, S. M., Green, C. A., Wisdom, J. P., Duan, N., & Hoagwood, K. (2015). Purposeful Sampling for Qualitative Data Collection and Analysis in Mixed Method Implementation Research. *Administration and Policy in Mental Health and Mental Health Services Research*, *42*(5), 533-544. https://doi.org/10.1007/s10488-013-0528-y

Patridge, E. F., & Bardyn, T. P. (2018). Research Electronic Data Capture (REDCap). *Journal of the Medical Library Association*, *106*(1), 142. https://doi.org/10.5195/jmla.2018.319

Petersen, I., & Lund, C. (2012). Mental Health Service Delivery in South Africa from 2000 to 2010: One Step Forward, One Step Back. *South African Medical Journal*, *101*(10), 751-757.

Plastow, N. (2015). Broken minds need community care. *Mail & Guardian*. https://mg.co.za/article/2015-11-12-broken-minds-need-community-care/

Plastow, N., Coetzee, Z., De Vos, Z., Lotter, M., Engelbrecht, S., & Maharaj, S. (2015). Using the Vona du Toit Model of Creative Ability to Make a Difference in Mental Health Practice. *British Journal of Occupational Therapy 78,* 129.

Rabani, M., Towhidi, A., & Rahmati, A. (2011). The Relationship between Mental Health and General Self-Efficacy Beliefs, Coping Strategies and Locus of Control in Male Drug Abusers. *Addiction & Health*, *3*(3-4), 111-118. http://www.ncbi.nlm.nih.gov/pubmed/24494125%0Ahttp://www.pubmedcentral.nih.gov/articlerender.fcgi?artid=PMC3905536

Radnitz, A., Christopher, C., & Gurayah, T. (2019). Occupational therapy groups as a vehicle to address interpersonal relationship problems: mental health care users' perceptions. *South African Journal of Occupational Therapy*, *49*(2), 4-10. https://doi.org/10.17159/2310-3833/2019/vol49n2a2

Ramano, E. M. (2017). A comparison of two occupational therapy group programmes on the task-oriented functioning of mental health care users with major depressive disorders. https://repository.up.ac.za/handle/2263/65848

Sarsak, H. I. (2022). Arab healthcare professionals' knowledge and perception of occupational therapy. *Bulletin of Faculty of Physical Therapy*, *27*(1). https://doi.org/10.1186/s43161-022-00098-4

Sedgwick, P., & Greenwood, N. (2015). Understanding the Hawthorne effect. *BMJ* (Clinical research ed.), 351, h4672. https://0-doi-org.innopac.wits.ac.za/10.1136/bmj.h4672

Silaule, O. (2016). *Routine measurement of outcomes for mental health care users attending occupational therapy in an acute mental health care unit within a rural context* (Master thesis). University of the Witwatersrand, Johannesburg.

Silaule, O., & Casteleijn, D. (2021). Measuring Change in Activity Participation of Mental Health Care Users Attending an Occupational Therapy Programme in Rural South Africa. *South African Journal of Occupational Therapy 51*(3), 63-73. https://doi.org/10.17159/2310-3833/2021/vol51n3a8

South Africa. (2002, November 6). Mental Health Care Act, 2002 (Act no. 17 of 2002). Government Gazette, 24024.

South Africa. (2013, November 26). Protection of Personal Information Act, 2013 (Act no. 4 of 2013). Government Gazette, 37067.

South Africa. (2024, May 16). National Health Insurance, Act, 2023 (Act no. 20 of 2023). Government Gazette, 50664.

South African Department of Health. (2023). *National Mental Health Policy Framework and Strategic Plan 2023-2030*. https://www.health.gov.za/wp-content/uploads/2024/02/National-Mental-Health-Policy-framework-and-strategic-Plan-2023-2030.pdf

Statistics South Africa. (2020). *General Household Survey. Statistical Release*. https://www.statssa.gov.za/publications/P0318/P03182020.pdf

Tapal, A., Oren, E., Dar, R., & Eitam, B. (2017). The Sense of Agency Scale: A Measure of Consciously Perceived Control Over One's Mind, Body, and the Immediate Environment. *Frontiers in Psychology*, *8*. https://doi.org/10.3389/fpsyg.2017.01552

Taylor, R., Bowyer, P., & Fisher, G. (2023). *Kielhofner's Model of Human Occupation.* (7th ed.). Lippincott Williams & Wilkins.

Tew, J., Ramon, S., Slade, M., Bird, V., Melton, J., & Le Boutillier, C. (2012). *Social factors and recovery from mental health difficulties: A review of the evidence. The British Journal of Social Work, 42*(3), 443–460. https://doi.org/10.1093/bjsw/ bcr076

Thomas, G. (2013). *How to Do Your Research Project: A Guide for Students in Education and Applied Social Sciences*. Sage.

Toledano-González, A., Labajos-Manzanares, T., & Romero-Ayuso, D. M. (2018). Occupational Therapy, Self-Efficacy, Well-Being in Older Adults Living in Residential Care Facilities: A Randomized Clinical Trial. *Frontiers in Psychology*, *9*. https://doi.org/10.3389/fpsyg.2018.01414

Tomlinson, M., Baron, E., On, E., Of, I., Jintie, H. A., Health, N. M., & Priorities, I. (2016). Integrating Mental Health into South Africa's Health System: Current Status and Way Forward. *South African Health Review.*

Tomlinson, M., Grimsrud, A. T., Stein, D. J., Williams, D. R., & Myer, L. (2009). The Epidemiology of Major Depression in South Africa: Results from the South African Stress and Health Study. *South African Medical Journal 99*(5), 367-373.

Vancouver, J. B., Thompson, C. M., Tischner, E. C., & Putka, D. J. (2002). Two Studies Examining the Negative Effect of Self-Efficacy on Performance. *Journal of Applied Psychology*, *87*(3), 506-516. https://doi.org/10.1037/0021-9010.87.3.506

VERBI Software 2021, MAXQDA 2022, computer program, VERBI Software, Berlin.

Warner, R. (2012). *Applied statistics: from bivariate through multivariate techniques*. Sage.

Wilcock, A. A. (1998). Reflections on Doing, Being and Becoming. *Canadian Journal of Occupational Therapy*, *65*(5), 248-256. https://doi.org/10.1177/000841749806500501

Wong, S. R., Ngooi, B. X., Kwa, F. Y., Koh, X. T., Chua, R. J. J., & Dancza, K. M. (2022). Exploring the Meaning of Value-Based Occupational Therapy Services from the Perspectives of Managers, Therapists and Clients. *British Journal of Occupational Therapy*, *85*(5), 377-386. https://doi.org/10.1177/03080226211030095

Yalom, I. D., & Leszcz, M. (2005). *Theory and Practice of Group Psychotherapy, Fifth Edition* (5th ed.). Basic Books.

Zedel, J., & Chen, S. P. (2021). Client's Experiences of Occupational Therapy Group Interventions in Mental Health Settings: A Meta-Ethnography. *Occupational Therapy in Mental Health*, *37*(3), 278-302. https://doi.org/10.1080/0164212X.2021.1900763

Zhou, X. (2022). Mental health Self-Efficacy as a Moderator Between the Relationship of Emotional Exhaustion and Knowledge Hiding: Evidence from Music Educational Students. *Frontiers in Psychology*, *13*. https://doi.org/10.3389/fpsyg.2022.979037

APPENDICES

APPENDIX A: Mental Health Self-efficacy scale (MHSES)

MHSES questionnaire generated by REDCap

MHSES

Please read each question and rate how confident you are that, on an average day in the next month, you will be able to do the following things.

On an average day in the next month, how confident are you that...

	1 Not confident at all	2	3	4	5	6	7	8	9	10 Totally confident
You can keep your stress, anxiety, or depression from interfering with the things that you want to do?	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
You can do the different tasks and activities needed to manage your stress, anxiety, or depression to reduce your need to see a doctor?	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
You can do things other than just taking medicine to reduce how much your stress, anxiety or depression affects your everyday life?	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
You can make your days at least moderately enjoyable?	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
You will have moderate amounts of time where you do not experience stress, anxiety, or depression?	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
You will be able to effectively manage any stress, anxiety, or depression that you do experience?	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

APPENDIX B: Pre-test Questionnaire

Pre-test questionnaire generated by REDCap

Before 'Puzzle of my life' Group

Please complete the below questionnaire, If you have any questions please ask the researcher

Thank you for participating

Please enter your patient number	_____ (You can find your patient number on your wristband or on the sticker on the top of your program.)
Pre-test	
How old are you?	_____ (If you are under 18, you do not meet the criteria to participate in this study. Please stop here and hand questionnaire back to the researcher.)
Is your main mental health diagnosis 'Major Depressive disorder (MDD)'?	◯ Yes ◯ No (If you answer 'no', you do not meet the criteria to participate in this study. Please stop here and hand questionnaire back to the researcher.)
Are you currently receiving ECT (Electroconvulsive Therapy)?	◯ Yes ◯ No (If you answer 'yes' you do not meet the criteria to participate in this study. Please stop here and hand questionnaire back to the researcher.)
What is your gender?	◯ Female ◯ Male ◯ Other, please specify
Please define 'Other' _____	
What is your race?	◯ Black ◯ White ◯ Indian ◯ Colored ◯ Other, please specify
Please define 'Other' _____	
What is you highest level of education?	◯ Primary or less ◯ High school ◯ Undergraduate degree ◯ Post-graduate degree ◯ Other, please specify
Please define 'Other' _____	

What is your marital status?

- ☐ Single
- ☐ Married
- ☐ Divorced
- ☐ Widowed
- ☐ Other, please specify

Please define 'Other'

_____

What is your employment status?

- ◯ Employed, full time
- ◯ Employed, part time
- ◯ Unemployed
- ◯ Studying
- ◯ Other, please specify

Please define 'Other'

_____

If you are employed, what is your field of employment?

_____

How many days have you been at the hospital for so far?

_____

Do you have any additional mental health disorders?

_____

How many previous admissions have you had to a mental health or psychiatric hospital?

_____

Do you know when you will be discharged?

- ◯ Yes
- ◯ No

If yes, how many days until you are discharged?

_____

	1 Not at all	2	3	4	5	6	7	8	9	10 Absolutely
Do you feel ready for discharge?	◯	◯	◯	◯	◯	◯	◯	◯	◯	◯

What is your mood right now?

◯ Depressed ◯ Sad ◯ Neutral ◯ Content ◯ Happy

APPENDIX C: Post-test Questionnaire

Pre-test questionnaire generated by REDCap

After 'Puzzle of my life' Group

Please complete the below questionnaire, If you have any questions please ask the researcher.

Thank you for participating!

Please enter your hospital number (you can find it on your wristband or on the sticker on your program) _____

Post-test

Did you attend all 4 days of Puzzle of my life?
- ◯ Yes
- ◯ No

What other treatments have you engaged in this week while you were doing the 'Puzzle of my life' group?
- ☐ Psychology
- ☐ Psychiatry
- ☐ OT Activity groups
- ☐ OT skills groups
- ☐ Psychoeducation groups run by group facilitators
- ☐ Pastoral counselling
- ☐ Music therapy
- ☐ Social Work
- ☐ Other

(You can select multiple boxes)

Please define 'Other'

_____

Do you know when you will be discharged?
- ◯ Yes
- ◯ No

If yes, how many days until you are discharged? _____

	1 Not at all	2	3	4	5	6	7	8	9	10 Absolutely
Do you feel ready to be discharged?	◯	◯	◯	◯	◯	◯	◯	◯	◯	◯

What is your mood right now?

◯ Depressed ◯ Sad ◯ Neutral ◯ Content ◯ Happy

APPENDIX D: Information sheet

**All participants should be offered a copy of the Participant Information Document to keep for their records.*



STUDY INFORMATION DOCUMENT

Study title: '*Exploring how Occupational Therapy Interactive Group intervention develops self-efficacy to impact discharge preparedness in clients with MDD at a private acute inpatient psychiatric setting in South Africa: a mixed methods study'*

Dear Sir/Madam

Introduction: My name is Charis Papageorgiou, I am conducting research on the '[redacted] group to see to how it improves your confidence to implement skills you have learnt in order to prepare you for discharge. Research is a process used in seeking new knowledge. In this study I want to learn more about how this model assists in developing your belief in yourself and feeling confident in your abilities to succeed in dealing with stress, anxiety, and depression. In order to improve your preparedness for discharge at and acute, voluntary psychiatric hospital. I am specifically observing the clients with a main diagnosis of a 'depressive disorder'. This study will provide evidence for this type of group using the 'mental health self-efficacy scale' (MHSES). Additionally, it will be supported by an interview to determine the specific impact of this type of group.

Invitation to Participate: I am inviting you to take part in a research study through completing a questionnaire before you participate in all four days of the '[redacted] group. You may volunteer to participate in an interview.

What is involved in the study: Should you provide consent to participate in the study please inform me to provide you with the questionnaire that will take 2-5 minutes to complete. You will also be given the opportunity to volunteer to be interviewed where I will then conduct an interview following a set of open-ended questions to gain a clear understanding of how the group impacted your confidence and preparedness for discharge.

Benefits of being a part of the study: There is no direct benefit. The information obtained in this study will be used to provide evidence for the use of the '[redacted] model's impact on building confidence to implement skills and preparedness for discharge. You will be given important information on the study while involved in the project and after the results are available and should be offered a free results summary, on request. There is low risk in participating in this study. You may experience some discomfort when completing questionnaires or during the interview reflecting on your progress in therapy to assist you with discharge preparation. If you become distressed during the interview, I will assist in regulating your emotions and refer you for additional support from your treating team to focus on discharge planning.

Participation is voluntary: You have the option of whether or not you would like to opt in to participate in the research. Refusal to participate will not involve any penalty or loss of benefits and will be able to participate in the group as you have been referred. You may discontinue participation at any time without penalty, or loss of benefits to which you are otherwise entitled. You do not need to provide a reason for withdrawing and any data collected on you will be destroyed unless you specifically consent to its retention.

Confidentiality: Personal information will be coded and deidentified. Personal information will be treated in the strictest confidence and will only be available to me, the researcher, and my supervisors, as I am a postgraduate student. The only exceptions - and all of them are rare - would normally be:

1. Personal information may be disclosed if required by law.

2. The Human Research Ethics Committees of the University may require personal data to respond to a formal complaint, or for a compliance audit.

3. The South African Health Products Regulatory Authority (SAHPRA) might conceivably require access to personal data, if conducting an investigation into a drug trial.

You should be assured that no individual will be identified by name in any report or publication arising out of the study. All data collected during the study will be securely retained for two (2) years if a scientific publication arises from the study and six (6) years if there is no publication. Thereafter the data will be destroyed accordingly.

Contact details of researchers:

Charis Papageorgiou, researcher: 1353958@students.wits.ac.za

Juwairiyya Paruk, Supervisor: juwairiyya.paruk@wits.ac.za

Itumeleng Tsatsi-Mosala, Supervisor: itumeleng.tsatsi-mosala@wits.ac.za

Outputs: This study will be submitted as an academic research project and the findings of the study may be shared with all participants if requested.

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

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

If you have any concern over the way the study is being conducted, please contact the Chairperson of this Committee who is Prof Paul Ruff, who may be contacted by e-mail on Paul.Ruff@wits.ac.za. The telephone numbers for the Committee secretariat are 011 717 2700/1234/2656/1252 and the e-mail addresses

are *Zanele.Ndlovu@wits.ac.za, Rhulani.Mukansi@wits.ac.za,Mapula.Ramaila@wits.ac.za and Iain.Burns@wits.ac.za .'*

Thank you for reading this Study Information Sheet.

Date: May 2024



Charis Papageorgiou

APPENDIX E: Recruitment of participation letter

I am inviting you to take part in a research study to increase the understanding and development of OT groups which are designed to help people cope and manage daily life.

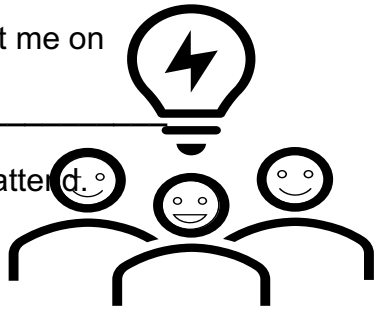
The study will involve you completing a short questionnaire before and after you participate in the '[redacted] group.

If you would like to participate, still not sure, or are curious, please meet me on

_____

It will take approximately 5-10 minutes. You are under no obligation to attend.

Looking forward to receiving your feedback!



APPENDIX F: Interview guide for qualitative data

Interview Schedule to meet Objective 4: To describe how occupational therapy interactive group intervention influences self-efficacy impacting client's preparedness for discharge.

Type of interview: In-person semi-structured interviews.

Estimated Duration: Approximately 30-45 min (to be reviewed once all interviews conducted)

Arrangements for the interview: The researcher will ask for a volunteer from the quantitative group and set up a meeting at a time that is suitable for the participant before they are discharged from the hospital, preferably 0-2 days after the group concludes.

Introduction of the session: The researcher will welcome the participant and thank them for participating in the study and ensuring confidentiality. Following this, the researcher will explain that the purpose of the interview is to have an open discussion about how the four-day closed OTIGM group to improve their self-efficacy to promote preparedness for discharge.

The interview will commence with an open-ended question and follow up with probing questions.

Final Interview guide (Adjustments made after practice with an OT, MHCU and interviewed peer-reviewed 30/05/2024)	
Main questions	**Probing questions**
introduction	Bring something from POML, building rapport (How was your day?)
Can you describe your experience of the '[redacted] group?	
What was your belief in your own ability to deal with your symptoms of depression before starting POML?	
Can you share any specific activities or discussions from	How did your (group vibe/group dynamics) interactions with other group members

Final Interview guide (Adjustments made after practice with an OT, MHCU and interviewed peer-reviewed 30/05/2024)	
Main questions	**Probing questions**
the group sessions that stood out to you?	influence your experience of the group? What helped you the most during groups?
Can you describe if there were any coping skills you learned from POML that you plan to continue using after discharge?	Can you give me an example of a skill you have already applied (link to their contribution) Have you faced any challenges in applying the skills learned in POML to your life so far? Have you noticed any changes in your attitudes or beliefs about your ability to manage your mental health and daily life? Since staring the group are your days more or less enjoyable. Do you think this will continue when you go home?
How do you feel about being discharged?	What are your expectations about going home (Prompt specific link to OPAs can give examples)? What parts of going back to your daily life do you feel ready for, and what parts do you feel unprepared for? Previous admission: Since you were admitted at a psychiatric facility previously, is you feeling of being discharged different or the same as last time? We hope your symptoms don't come back, if they do? How do you feel about your ability to cope with symptoms of depression if they were to reoccur? What do you think could be improved from the group to better support you in being discharged? What should stay the same?

General Prompts:

Probes: prompts (repetition), "what about the group made _____possible" "how did the group help with ____" "I hear you saying …."

APPENDIX G: Distress protocol

This study is low risk according to the Medical Human Ethics Research Committee (HERC). There is low risk of psychological distress during the qualitative interview where the “only foreseeable risks are that of temporary discomfort, or where there may be some sensitivity involved in terms of the questions asked”.

Method of inquiry: In the quantitative questionnaire when reflecting on coping with stress, anxiety and depressive symptoms and/or identifying current mood. In the qualitative interview questions will be asked about their experience and opinions about the OTIGM treatment they received while in the hospital as well as how prepared the feel to be discharged and return to their home environments. These may be potentially sensitive questions particularly if participants have any anxiety/concerns about their current emotional state/therapeutic progress/going home.

Research population: The participants in the study form part of a vulnerable group as they are MHCUs diagnosed with MDD. The population of participants have emerging abstract concepts and are capable of providing informed consent as these are requirements of the OTIGM. The participant is a MHCU accessing services at the in-patient hospital with a treating psychiatric team which may include a psychologist, psychiatrist and social worker. These health professionals are currently assisting the participant with discharge preparation and often follow up with MHCU after discharge.

The procedure: In the event that the participant experiences emotional or psychological distress either by indicating that they are experiencing a high level of stress or emotional distress, or by exhibiting behaviour such as a trembling voice, crying or shaking. The PI is to follow the below stipulated procedure:

1. Stop the interview.
2. Assess the psychological/emotional status of the participant by probing what their thoughts and feelings are.
    a. If the participant indicates that they feel able to continue, resume the interview.

b. If not, arrange to reschedule an appointment to continue with the interview and encourage the participant to discuss this emotional response with their psychologist who assists with containing and processing participant's emotional state which is appropriate since the participant is already their patient.

Objective 2: Give feedback to treating team with the participant's consent to report on participant's emotional state and for monitoring/support to provide to the participant when they return to the ward. For treating team to support in participant's discharge procedure.

Objective 3: If the participant consents, to follow up with a courtesy visit while they are still in the hospital before they are discharged.

APPENDIX H: Permission letter to do research at the practise.

WITS UNIVERSITY 100 1922 2022 | FACULTY OF HEALTH SCIENCES

[redacted]

I am writing to formally request your permission to conduct research within your occupational therapy practice [redacted] This research will be in fulfillment of a master's degree in occupational therapy at the university of the Witwatersrand in 2023/24. My proposed research dissertation aims to explore the relationship between self-efficacy and preparedness for discharge, facilitated through the Occupational Therapy Interactive Group Model within the context [redacted] of Juwairiyya Paruk and Itumeleng Tsatsi-Mosala from the Department of Occupational Therapy in the School of Therapeutic Health Science at the University of the Witwatersrand.

The proposed methodology will utilize a mixed methods approach, combining quantitative and qualitative data collection methods. The research will be conducted voluntarily, and participants will be invited to opt-in before attending the [redacted] consent will be obtained from all participants prior to their involvement in the study. For the quantitative component, a pre-test and post-test questionnaire will be administered (demographics questionnaire, rating of preparedness for discharge and the use of the Mental Health Self-efficacy scale). The qualitative component will involve semi-structured interviews with participants who are being discharged within the next three days after completing the series. These will be combined in the findings to measure the impact of the occupational therapy intervention on self-efficacy and preparedness for discharge. The research is expected to take place over a 3-month period towards the end of 2023 and beginning of 2024

I, [redacted], give Charis Papageorgiou permission to conduct research in line with the above information on clients attending 'Puzzle of My Life' series in fulfilment of Master's research upon acceptance of ethical clearance.

1. I have been given an Information Sheet (above) which explains the nature and processes involved in this study, which is attached hereto.

2. I was given time to read it, or had it read to me, in the language I best understand.

3. I was given time to ask any questions I wanted to and found any answers given to me to be reasonable and satisfactory and to ensure best interests of therapists/employees at the practise and does not hinder the flow of the procedures of the occupational therapy program.

4. I fully understand why the study is being conducted and what the intended outcomes will be.

5. I may withdraw consent in case that ethical procedures for client's and/or employees of CL Stander & Associates are violated. The ethics number and approval letter will be promptly provided once acquired, ensuring compliance with all necessary ethical guidelines and regulations.

6. I have been given a range of contact details, listed below. If I require further information or become concerned about any aspect of this study, I am free to speak to any of these contacts.

   Contact details: Charis Papageorgiou, Researcher, telephone no. 071 816 0321, or by 1353958@students.wits.ac.za. My supervisors can be contacted on itumeleng.tsatsi-mosala@wits.ac.za or juwairiyya.paruk@wits.ac.za. Professor CB Penny, Chairperson of the Human Research Ethics Committee (Medical) at the University of Witwatersrand, on telephone no. 011 717 2301, or by e-mail at Clement.Penny@wits.ac.za. Ms. Z Ndlovu or Mr. Rhulani Mkansi, Committee Secretariat, telephone nos.: 011 717 2700 or 1234, or by e-mail at: Zanele.Ndlovu@wits.ac.za or Rhulani.Mkansi@wits.ac.za

[redacted]

Signature: _____ Date: 21 July 2023

Charis Papageorgiou

Dear [redacted]

Subject: Request for Permission to Conduct Research at [redacted] to fulfil master's degree in occupational therapy at the university of the Witwatersrand.

My name is Charis Stols an Occupational therapist employed at [redacted]; I am completing my master's degree in 2023/24. I am writing to formally request your permission to conduct research at [redacted]. The research dissertation aims to explore the relationship between self-efficacy and preparedness for discharge, facilitated through the Occupational Therapy Interactive Group Model within the context of a private psychiatric setting. The research will be conducted as part of a parallel convergent mixed methods study under the supervision of Juwairiyya Paruk and Itumeleng Tsatsi-Mosala from the Department of Occupational Therapy in the School of Therapeutic Health Science at the University of the Witwatersrand.

The purpose of this study is to investigate how the implementation of the occupational therapy interactive group model influences self-efficacy and contributes to the preparedness for discharge among patients in a voluntary acute psychiatric hospital. This model is used to structure the [redacted] which is offered by the Occupational therapy department, [redacted]. The research will utilise a parallel convergent mixed methods approach, including quantitative and qualitative data collection methods. The research is expected to take place over a 3-month period towards the end of 2023 and beginning of 2024.

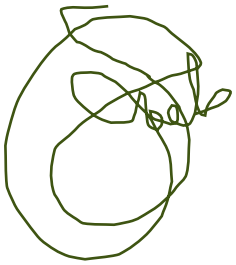
The research will be conducted voluntarily, and participants will be invited to opt-in before attending the [redacted] series. Informed consent will be obtained from all participants prior to their involvement in the study. For the quantitative strand, a pre-test and post-test questionnaire will be administered (demographic information, rating of preparedness for discharge and the use of the Mental Health Self-efficacy scale). The qualitative strand will involve semi-structured interviews with participants who are being discharged within the next three days after completing the series. These will be combined in the findings to measure the impact of the occupational therapy intervention on self-efficacy and preparedness for discharge.

It is important to note that at this stage, I am still awaiting ethical clearance, which is in the application process. The ethics number and approval letter will be promptly provided to your institution once acquired, ensuring compliance with all necessary ethical guidelines and regulations.

This research is supported by [redacted]s. I sincerely appreciate the opportunity to conduct this research within your esteemed acute psychiatric hospital. The results of this study will contribute to the growing body of knowledge on occupational therapy interventions and their impact on patients' self-efficacy and preparedness for discharge. It is my hope that the findings will provide valuable insights for the development of effective intervention strategies to enhance the overall well-being and successful transition of patients in acute psychiatric care. The findings of this study will be made available to you on request.

If you require any additional information, documentation or have any queries please do not hesitate to contact me at 1353958@students.wits.ac.za or on 071 816 0321. My supervisors can be contacted on itumeleng.tsatsi-mosala@wits.ac.za or juwairiyya.paruk@wits.ac.za for any further inquiries. You can also contact the owner of the occupational therapy practice [redacted]

Yours sincerely,



Charis Stols

Student Number: 1353958

Department of Occupational Therapy

School of Therapeutic Health Science

University of the Witwatersrand

APPENDIX I: Data management program

Component of Data Management	Management Plan for this Study
Types of Data 1. What types of data will you be creating or capturing? (Experimental measures, observational or qualitative, model simulation, existing) 2. How will you capture, create, and/or process the data? (Identify instruments, software, imaging, etc. used)	1. Quantitative and qualitative data was used for the research study. 2. Capturing: Quantitative data was captured Pre- and Post-test Questionnaire and the MHSES. Qualitative data used audio recordings of semi- structured individual interviews. The Voice Memo app was used to record to record the in-person interviews. The recordings were transcribed in Descript app and exported in word documents. These transcriptions were uploaded MAXQDA software to be analysed and saved on OneDrive.
Contextual Details (Metadata) 1. What file formats and naming conventions will you be using?	1. Quantitative data was identified during the analysis in excel documents and was password protected. Qualitative data audio data and transcriptions are be stored on One Drive. Audio recordings and transcriptions were be named with the first two letters of the participants later and later changed to pseudonyms in the data findings.
Storage Backup and Security 1. Where and on what media will you store the data? 2. What is your backup plan for the data? 3. How will you manage data security?	1. Both the Quantitative and Qualitative data was stored on the researcher's' Microsoft OneDrive which is password protected. 2. Data was backed up on the University of the Witwatersrand Cloud, which only the researcher has access to. 3. The data was encrypted and stored on a password-protected computer to ensure security. • After the study has ended and the student has submitted the dissertation for examination, all data was handed over to the Department of Occupational Therapy to be stored in its digital research repository. • Data was archived by the University library two years after the student graduates.
Provisions for Protection/Privacy 1. How are you addressing any ethical or privacy issues (IRB, anonymisation of data)? 2. Who will own any copyright or intellectual property rights to the data?	1. Quantitative data was identified with codes before it is analysed, and the same codes were used for the qualitative data to ensure anonymity of data. The real names and codes were stored only in hard documents, stored in a locked cupboard. The audio recordings were not uploaded. 2. Intellectual property rights belong to the University of the Witwatersrand. All raw data (including the recordings) was handed over at the end of the project and the data was labelled as "sensitive."
Policies for Re-use 1. What restrictions need to be placed on re-use of your data?	1. Consent from the researcher and the Department of Occupational Therapy in accordance with the University's data access policies, will be required before access will be granted to someone who wishes to use the data. Ethical clearance from the HREC-M was obtained (see APPENDIX R).
Policies for Access and Sharing 1. What is the process for gaining access to your data?	1. In lieu of a data management committee at the University of the Witwatersrand, anyone wishing to gain access to the data will need to apply through the HREC-M

APPENDIX J: Participant consent form

PARTICIPANT CONSENT FORM.

Title: Exploring the relationship between self-efficacy and preparedness for discharge facilitated through the occupational therapy interactive group model at a private acute inpatient psychiatric setting in South Africa: A mixed methods study

1. I have been given a Participant Information Sheet which explains the nature and processes involved in this study, which is attached hereto.
2. I was given time to read it, or had it read to me, in the language I best understand.
3. I was given time to ask any questions I wanted to and found any answers given to me to be reasonable and satisfactory.
4. I fully understand why the study is being conducted and what the intended outcomes will be.
5. I understand that there will be no immediate benefit to me, should I agree to participate, nor will I receive any payment; conversely, participation will not cost me anything but my time.
6. I understand that, even if I initially consent to take part in the study, I may subsequently withdraw at any time and would not be required to give any reasons; if that happened, any data collected about me for the study would immediately be destroyed, unless I give consent for it to be retained.
7. I agree that the researcher may access my hospital records in alignment with the POPIA.
8. I have been given a range of contact details, listed below. If I require further information or become concerned about any aspect of this study, I am free to speak to any of these contacts.

Contact details: Charis Papageorgiou, Researcher, telephone no. 071 816 0321, or by 1353958@students.wits.ac.za Professor CB Penny, Chairperson of the Human Research Ethics Committee (Medical) at the University of Witwatersrand, on telephone no. 011 717 2301, or by e-mail at Clement.Penny@wits.ac.za. Ms. Z Ndlovu or Mr. Rhulani Mkansi, Committee Secretariat, telephone nos.: 011 717 2700 or 1234, or by e-mail at: Zanele.Ndlovu@wits.ac.za or Rhulani.Mkansi@wits.ac.za

Name of Participant: _____

Signature: _____ Date: _____ Place: _____

APPENDIX K: Consent form for Audio

AUDIO CONSENT FORM

Title: 'Exploring how Occupational Therapy Interactive Group intervention develops self-efficacy to impact discharge preparedness in clients with Major depressive disorder at a private acute inpatient psychiatric setting in South Africa: a mixed methods study'

I hereby consent to Audio recording of the semi-structured interview. I understand that:

- The audio recording will be stored in a secure location (a locked cupboard or password protected computer) with restricted access to the researcher and the research supervisor.
- The audio recording will be transcribed, and field notes will be taken, any information that could identify me will be removed.
- The recordings will be erased within either.
    - two (2) years of the publication of the research findings, or
    - six (6) years, if no publications arise from this research.
- Anyone wishing to access this information in the future will first have to obtain the approval of the Human Research Ethics Committee (Medical) of the University of the Witwatersrand, Johannesburg
- Direct quotes from my interview, without any information that could identify me, may be cited in the research report or other write-ups of research.

Name of Participant: _____

Signature: _____ Date: _____ Place: _____

APPENDIX L: Data collection information distributed within the hospital

Information shared with Occupational Therapists who would be assisting with data collection

Hi colleague,

Please assist me in the data collection for my research study, I would really appreciate it. It will hopefully help us to see how our groups are benefiting our clients and investigate where improve!

Please find the expectations and how you can assist me below:

- The participants will be requited on the Monday morning at 8:30 before they start group.
    - If the someone is attending 9:00 activity I will send a message on the Practice Program WhatsApp group to inform you how many clients to keep space for in case, they are running late.
- I need 75 participants which will hopefully take 3-4 weeks…
- On day 1:
    - The client will have already completed the questionnaire in the morning.
    - If they ask to also participate, they may ask you for a questionnaire that they can complete quickly before your group starts if these is feasible (check their vcode).
- On day 4:
    - I will send a WhatsApp reminder to collect an envelope from my desk to take to your group.
    - Once you have closed your group on day 4, please ask your group who filled out the questionnaire *hold up Pre-test questionnaire*. Provide those participants with the post-test questionnaire.
    - When they have completed the questionnaire, please make sure they write their v code in the allocated spot before placing it in the envelope provided.
    - You can leave your envelopes on my desk in a box labelled “Charis Masters research”

Please let me know if you are having any problems or want to make a suggestion

Thank you!!

Charis

APPENDIX M: Data collection information distributed within the hospital

8.13.2 This email was sent out to nursing Matron to inform her of the research

Good day,

I hope you are doing well!

The OT department is conducting research to inform our services and reflect on how the [redacted] groups impacts preparing our clients for discharge through facilitating change in their self-efficacy. The research is being directed by Charis Stols, one of our Senior OTs, for her master's research.

The research will commence on the 6th of May 2024. Potential participants will receive a small note attached to their programs to invite them to an information session in OT Annex prior to attending [redacted] on Mondays from 8:30-9:00 and 12:00-12:30.

Please reach out on email: 1353958@students.wits.ac.za or call the OT department if you have any queries

8.13.3 This image was sent out on WhatsApp to all clinicians at the hospital to make them aware of the research and invitations



APPENDIX N: Predetermined codes and definitions

Table 6.1: A Table indicating the codes with definitions and operational definitions for guidance in coding of transcriptions following the initial process of directed content analysis

	Code Category with Definition	Concept Breakdown	Possible Codes	Definitions and Operational Definitions
Key Concept 1: Self-efficacy	Self-efficacy: is the belief in one's capabilities to organise and execute action. It reflects an individual's confidence in their ability to perform tasks and achieve goals, influencing their approach to challenges and their perseverance in the face of obstacles.	*Concepts are broken down into the four components below which in influence a guide a person's belief in themselves.*	Empowered	Definition: The feeling or belief in one's abilities and judgments, leading to a positive expectation of success. Operational Definition: Note references to participants expressing confidence in their skills or decisions, willingness to undertake tasks, and instances where participants display proactive behaviour in therapy sessions.
			Belief in self	Definition: The internal conviction in one's own worth, capabilities, and potential to succeed. Operational Definition: Data Indicators: Statements reflecting positive self-regard, instances of self-affirmation, or actions taken based on a strong sense of personal potential and value.
	Mastery Experiences Building confidence through success. Personal successes and accomplishments that build confidence in one's abilities. Direct personal experiences of success in completing tasks and overcoming challenges, which reinforce a belief in one's capabilities.	*Successful task completion*: Achieving goals and completing tasks effectively. *Overcoming challenges*: Successfully managing and overcoming difficult situations. *Positive reinforcement*: Experiencing positive outcomes from efforts. *Progressive achievements*: Building skills and confidence through a series of incremental successes.	Success	Definition: Gaining confidence through personal accomplishment or successfully managing a challenging situation. The attainment of a specific goal or milestone, reflecting progress and competence. Operational Definition: Statements reflecting successful personal achievements or overcoming challenges through the group activities.
			Skill reinforcement,	Definition: The process of strengthening and validating a skill through repeated successful application and positive feedback. Operational Definition: Moments where participants discuss receiving positive reinforcement for successfully applying a skill or describe how repeated successful use of a skill has increased their confidence and ability to use it effectively in various contexts.
			Challenge overcoming	Definition: The act of successfully managing and overcoming difficult situations or obstacles, which enhances self-efficacy. Operational Definition: Look for examples where participants recount facing and overcoming difficulties, which contribute to their sense of resilience and capability.

	Code Category with Definition	Concept Breakdown	Possible Codes	Definitions and Operational Definitions
			Practice skill	Definition: The repeated use of a particular skill or technique to enhance proficiency and confidence in its application. Operational Definition: Identify references where participants talk about practicing specific skills during therapy or in their daily lives, which helps to build their competence and confidence.
	Vicarious Experiences: Observing others perform tasks successfully, especially those perceived as similar to oneself, which can enhance belief in one's own abilities.	*Role modelling*: Learning and gaining confidence by watching others perform tasks. *Social comparison*: Comparing oneself with others to gauge capabilities. *Learning through observation*: Gaining insights and skills from observing others' experiences. *Influence of similar individuals*: Being inspired by people who are relatable and similar to oneself	Role model	Definition: An individual whose success or behaviour serves as an example to others, inspiring and motivating them to believe in their own capabilities. Operational Definition: Instances where participants mention looking up to or being inspired by a group member's actions or success.
			Peer success	Definition: Gaining confidence by observing others successfully managing similar challenges. Operational Definition: Statements indicating that observing or hearing about others' successes influenced one's own self-efficacy.
			Observational learning	Definition: Acquiring new skills or strengthening existing ones by watching others perform tasks successfully. Operational Definition: Look for descriptions of participants learning new skills or gaining confidence by observing others, particularly in situations where the observed person is perceived as similar to the participant.
			Social comparison	Definition: The process of evaluating one's own abilities and progress by comparing oneself to others in the group. Operational Definition: Look for mentions where participants reflect on their own abilities by comparing themselves to others, noting whether this comparison has led to increased self-efficacy or motivation.
			Universality	Definition: The realisation that others share similar experiences, challenges, and feelings, which can reduce feelings of isolation and enhance self-efficacy. Operational Definition: Identify moments where participants express relief or motivation after recognising that their struggles or experiences are shared by others in the
	Verbal Persuasion: Positive verbal feedback and encouragement from	*Encouragement from others*: Receiving supportive and motivational words.	Encouragement	Definition: Gaining confidence through encouragement and positive feedback from others. Operational Definition: Statements reflecting encouragement, support, and positive reinforcement from group members or facilitators.

	Code Category with Definition	Concept Breakdown	Possible Codes	Definitions and Operational Definitions
	others, which can strengthen belief in one's abilities to succeed.	*Constructive feedback*: Getting useful and positive critiques to improve performance. *Positive affirmations*: Hearing affirming statements that boost confidence. *Motivational support*: Being motivated and supported by others' words.	Positive feedback	Definition: Supportive verbal comments that reinforce and validate a person's abilities. Operational Definition: Identify instances where participants receive and discuss encouraging feedback from others that boosts their confidence.
			Affirmation	Definition: Verbal statements that confirm and support an individual's abilities and achievements. Operational Definition: Look for mentions where participants describe receiving affirming statements that help build their self-belief.
			Motivational support	Definition: Encouraging and inspiring words that drive individuals to persist and succeed. Operational Definition: Identify references where participants talk about being motivated by others' supportive words or encouragement.
	Physiological and Emotional States: Physiological and emotional responses triggered by stressful situations, influencing one's perceived competence and anxiety.	*Stress management*: Effectively handling and reducing stress levels. *Anxiety levels*: Managing and controlling feelings of anxiety. *Emotional regulation*: Maintaining and regulating emotions in a healthy manner. *Physical health and well-being*: Ensuring good physical health and a sense of well-being.	Emotional state	Definition: Gaining confidence through the management and interpretation of emotional and physiological responses. Operational Definition: Statements indicating changes in emotional states or how the group's activities impacted emotional well-being.
			Bodily experience	Definition: Physical sensations and responses associated with emotional or psychological state. Operational Definition: Identify instances where participants describe physical sensations during activities and how these sensations are linked to their emotional or psychological experiences. Descriptions where physical experiences are used metaphorically to express or explain underlying mental or emotional burdens.
			Positive experience	Definition: Positive physiological and emotional responses that contribute to a sense of well-being and reduced anxiety. Operational Definition: Identify references where participants discuss experiences that lead to improved emotional regulation, positivity, reduced anxiety, or better physical health and well-being.

	Code Category with Definition	Concept Breakdown	Possible Codes	Definitions and Operational Definitions
Key Concept 2: Preparedness for discharge:	Preparedness for discharge	**Emotional readiness**: Emotional response to going home. Goal attainment: Perception of progress of treatment goals and/or expectations. Application: of skills outside of the group in hospital environment and application while inside the hospital with the outside environment (finding a new job or support group, addressing conflict telephonically) Community reintegration: Occupational deprivation: continued decrease in occupational performance when going home can lead to re-admission. Challenge in application to outside environment: development of healthy relationships within a safe and supportive environment to transition to the 'unsafe' community environment.	Occupational performance areas	Definition: The key aspects of daily living activities, including self-care, productivity, and leisure, that participants engage in. Operational Definition: Identifying instances where participants share on perceived ability to perform in different areas (daily activities, work, social, rest, leisure).
			Readiness	Definition: The state of being prepared to transition from the hospital to the home environment, both physically and mentally. Operational Definition: Instances where participants articulate their sense of preparedness or lack thereof for discharge, including their emotional experience, goal attainment, skill development.
			Relapse	Definition: The recurrence of symptoms or deterioration in mental health after a period of improvement, particularly after discharge from the hospital. Operational Definition: Identifying instances where participants express concerns about returning to old habits, fear of symptom recurrence, or discuss past experiences of relapse, which may indicate their awareness and readiness to manage potential setbacks after discharge.
			Application	Definition: The ability of participants to apply skills learned in therapy to real-life situations within and outside the hospital environment. Operational Definition: Look for examples where participants describe how they are using or plan to use coping strategies, problem-solving techniques, or other therapeutic tools in their daily life.
			Future planning	Definition: The process by which participants consider and make plans for their life post-discharge, including setting goals and identifying necessary resources. Operational Definition: Moments where participants discuss their plans for the future, such as finding a job, reconnecting with family, or continuing therapy, which indicate their level of engagement in planning for life after discharge.

	Code Category with Definition	Concept Breakdown	Possible Codes	Definitions and Operational Definitions
Key Concept 3: OTIGM	Learning	Experiential learning can occur when participants participate in therapeutic activities, reflect on their experiences and responses, and then apply new skills or insights in their daily lives. Also links to 'practice skills' and 'present moment' codes	Learn through Activities	Definition: The process by which participants gain insights, knowledge, or skills through participation in therapeutic activities. Operational definition: Look for descriptions of how activities are used to prompt participant reflections, evidence of discussions or feedback sessions focused on what participants learned, and notes on how participants integrate these lessons into their daily lives or therapeutic goals.
	Key Components of OTIGM	**Client-Centred Approach:** The OTIGM follows a client-centred approach, where therapeutic activities and interventions are tailored to meet the individual needs and goals of group members. **Group Dynamics and Social Interaction**: Therapeutic activities are designed to promote group cohesion, social interaction. **Yalom's Curative Factors:** The OTIGM incorporates Yalom's curative factors, such as instilling hope, developing group cohesion, and promoting self-disclosure.	Client-centred	Definition: Tailoring therapeutic interventions to the individual needs and preferences of each group member. Operational Definition: The facilitator customises group activities and discussions based on each participant's specific goals, needs, and feedback, ensuring that interventions are relevant and personal.
			Universality (facilitated)	Definition: The recognition that others share similar experiences and feelings, promoting a sense of commonality and connection among group members. Operational Definition: The facilitator encourages sharing and discussion of common experiences or emotions within the group, helping members identify and relate to shared struggles and solutions.
			Social interaction	Definition: The process of engaging with others within the group to build relationships and develop social skills. Operational Definition: The facilitator designs and facilitates activities that promote active engagement, communication, and interaction between group members, encouraging them to practice and enhance their social skills.
			Instilling hope	Definition: Fostering a sense of optimism and belief in the possibility of positive change. Operational Definition: The facilitator uses motivational techniques, shares success stories, and provides encouragement to help participants build a sense of hope and motivation for their own recovery and growth.

	Code Category with Definition	Concept Breakdown	Possible Codes	Definitions and Operational Definitions
			Safe space	Definition: A secure and non-judgmental environment where group members feel comfortable expressing themselves. Operational Definition: The facilitator creates and maintains a supportive atmosphere by ensuring confidentiality, managing conflicts sensitively, and reinforcing a culture of respect and safety.
			Learn from others	Definition: Gaining insights and knowledge through observing and interacting with other group members. Operational Definition: The facilitator encourages participants to share their experiences and strategies, facilitating peer-to-peer learning through discussions, feedback, and mutual support.
			Catharsis	Definition: The process of releasing and expressing repressed emotions through therapeutic activities or discussions. Operational Definition: The facilitator facilitates activities and discussions that allow group members to express and process their emotions, helping them gain relief and insight through emotional release.
			Cohesion	Definition: The sense of unity and mutual support within the group. Operational Definition: The facilitator implements strategies and activities designed to build and strengthen group bonds, such as team-building exercises, shared experiences, and fostering a supportive group dynamic.
	Core Concepts	**Here and Now:** Present-moment engagement and awareness of emotions and behaviours. **Leading from Behind:** Participant autonomy, fostering independence. **Group as Mini Society:** Practice real-life social skills in group; experience of social, communication and conflict skills. **Group as Microcosm**: Reflect on behaviours mirroring real-world norms. **Changes to Society**: generalise	Illumination	Definition: The process by which participants gain insights or awareness about their behaviours, emotions, or social interactions within the group. Operational Definition: Instances where the facilitator or group activities explicitly prompt participants to reflect on or discuss their behaviours, emotions, or interactions, leading to new insights or awareness.
			Confrontation	Definition: Direct communication that highlights issues or behaviours, aimed at promoting self-awareness and positive change, within a supportive context in the group. Operational Definition: Look for instances where participants discuss being confronted about their behaviours or issues. Note whether they describe the confrontation as an eye-opener or as something they were defensive about. Also, identify any reported changes in behaviour or mindset resulting from these confrontations.

	Code Category with Definition	Concept Breakdown	Possible Codes	Definitions and Operational Definitions
		the insights and changes from the group to their daily lives The **Whole is Greater Than the Sum of its Parts**: Emphasises the collective benefit of shared support, feedback, and experiences within the group.	Identifying emotions	Definition: The ability of participants to recognise and articulate their emotions during group activities or discussions. Operational Definition: Moments when the facilitator guides participants to focus on and articulate their emotions.
			Encourage independence	Definition: The group's role in promoting self-reliance and personal decision-making among participants. Operational Definition: Activities, prompts, or strategies used by the facilitator to encourage participants to make decisions on their own, take initiative, or express personal opinions, fostering a sense of independence.
			Opportunity to practice skills	Definition: The chance provided by the group setting for participants to practice new social, emotional, or coping skills in a controlled environment. Operational Definition: Specific activities or structured interactions within the group that are designed to allow participants to practice and refine particular skills.
			Generalise to daily life	Definition: The relevance of group activities or insights to the participants' everyday experiences and challenges. Operational Definition: Interventions where the facilitator explicitly connects group activities or discussions to real-life situations, helping participants see how the skills or insights gained in the group are relevant to their past or future life.
			Present moment	Operational definition: in the moment they had any experience?? Definition: The focus on the current emotions, thoughts, and behaviours of participants during the group, emphasising mindfulness and immediate experience. Operational Definition: Techniques used by the facilitator to bring attention to the "here and now," such as mindfulness exercises, present-moment prompts, or activities that require immediate emotional or cognitive engagement.
			Advice	Definition: The exchange of guidance or suggestions among group members or from the facilitator to the participants. Operational Definition: Instances were giving and receiving of advice was noted amongst group members or the facilitator.
			Social skills practice	Definition: The use of group interactions to develop and refine interpersonal skills such as communication, empathy, and conflict

	Code Category with Definition	Concept Breakdown	Possible Codes	Definitions and Operational Definitions
				resolution. Operational Definition: Specific activities or exercises that allowed for the opportunity to practice social skills, such as group discussions, role-playing, or collaborative tasks/teamwork that require effective communication and interaction.

	Code Category with Definition	Concept Breakdown	Possible Codes	Definitions and Operational Definitions
Key Concept 3: OTIGM	Learning	Experiential learning can occur when participants participate in therapeutic activities, reflect on their experiences and responses, and then apply new skills or insights in their daily lives. Also links to 'practice skills' and 'present moment' codes	Learn through Activities	Definition: The process by which participants gain insights, knowledge, or skills through participation in therapeutic activities. Operational definition: Look for descriptions of how activities are used to prompt participant reflections, evidence of discussions or feedback sessions focused on what participants learned, and notes on how participants integrate these lessons into their daily lives or therapeutic goals.
	Key Components of OTIGM	**Client-Centred Approach:** The OTIGM follows a client-centred approach, where therapeutic activities and interventions are tailored to meet the individual needs and goals of group members. **Group Dynamics and Social Interaction**: Therapeutic activities are designed to promote group cohesion, social interaction. **Yalom's Curative Factors:** The OTIGM incorporates Yalom's curative factors, such as instilling hope, developing group cohesion, and promoting self-disclosure.	Client-centred	Definition: Tailoring therapeutic interventions to the individual needs and preferences of each group member. Operational Definition: The facilitator customises group activities and discussions based on each participant's specific goals, needs, and feedback, ensuring that interventions are relevant and personal.
			Universality (facilitated)	Definition: The recognition that others share similar experiences and feelings, promoting a sense of commonality and connection among group members. Operational Definition: The facilitator encourages sharing and discussion of common experiences or emotions within the group, helping members identify and relate to shared struggles and solutions.
			Social interaction	Definition: The process of engaging with others within the group to build relationships and develop social skills. Operational Definition: The facilitator designs and facilitates activities that promote active engagement, communication, and interaction between group members, encouraging them to practice and enhance their social skills.

	Code Category with Definition	Concept Breakdown	Possible Codes	Definitions and Operational Definitions
			Instilling hope	Definition: Fostering a sense of optimism and belief in the possibility of positive change. Operational Definition: The facilitator uses motivational techniques, shares success stories, and provides encouragement to help participants build a sense of hope and motivation for their own recovery and growth.
			Safe space	Definition: A secure and non-judgmental environment where group members feel comfortable expressing themselves. Operational Definition: The facilitator creates and maintains a supportive atmosphere by ensuring confidentiality, managing conflicts sensitively, and reinforcing a culture of respect and safety.
			Learn from others	Definition: Gaining insights and knowledge through observing and interacting with other group members. Operational Definition: The facilitator encourages participants to share their experiences and strategies, facilitating peer-to-peer learning through discussions, feedback, and mutual support.
			Catharsis	Definition: The process of releasing and expressing repressed emotions through therapeutic activities or discussions. Operational Definition: The facilitator facilitates activities and discussions that allow group members to express and process their emotions, helping them gain relief and insight through emotional release.
			Cohesion	Definition: The sense of unity and mutual support within the group. Operational Definition: The facilitator implements strategies and activities designed to build and strengthen group bonds, such as team-building exercises, shared experiences, and fostering a supportive group dynamic.
	Core Concepts	**Here and Now:** Present-moment engagement and awareness of emotions and behaviours. **Leading from Behind:** Autonomy, fostering independence.	Illumination	Definition: The process by which participants gain insights or awareness about their behaviours, emotions, or social interactions within the group. Operational Definition: Instances where the facilitator or group activities explicitly prompt participants to reflect on or discuss their behaviours, emotions, or interactions, leading to new insights or awareness.

	Code Category with Definition	Concept Breakdown	Possible Codes	Definitions and Operational Definitions
		Group as Mini Society: Practice real-life social skills in group; experience of social, communication and conflict skills. **Group as Microcosm**: Reflect on behaviours mirroring real-world norms. **Changes to Society**: generalise the insights and changes from the group to their daily lives The **Whole is Greater Than the Sum of its Parts**: Emphasises the collective benefit of shared support, feedback, and experiences within the group.	Confrontation	Definition: Direct communication that highlights issues or behaviours, aimed at promoting self-awareness and positive change, within a supportive context in the group. Operational Definition: Look for instances where participants discuss being confronted about their behaviours or issues. Note whether they describe the confrontation as an eye-opener or as something they were defensive about. Also, identify any reported changes in behaviour or mindset resulting from these confrontations.
			Identifying emotions	Definition: The ability of participants to recognise and articulate their emotions during group activities or discussions. Operational Definition: Moments when the facilitator guides participants to focus on and articulate their emotions.
			Encourage independence	Definition: The group's role in promoting self-reliance and personal decision-making among participants. Operational Definition: Activities, prompts, or strategies used by the facilitator to encourage participants to make decisions on their own, take initiative, or express personal opinions, fostering a sense of independence.
			Opportunity to practice skills	Definition: The chance provided by the group setting for participants to practice new social, emotional, or coping skills in a controlled environment. Operational Definition: Specific activities or structured interactions within the group that are designed to allow participants to practice and refine particular skills.
			Generalise to daily life	Definition: The relevance of group activities or insights to the participants' everyday experiences and challenges. Operational Definition: Interventions where the facilitator explicitly connects group activities or discussions to real-life situations, helping participants see how the skills or insights gained in the group are relevant to their past or future life.
			Present moment	Operational definition: in the moment they had any experience?? Definition: The focus on the current emotions, thoughts, and behaviours of participants during the group, emphasising mindfulness and immediate experience. Operational Definition: Techniques used by the facilitator to bring attention to the "here and now," such as mindfulness exercises, present-

	Code Category with Definition	Concept Breakdown	Possible Codes	Definitions and Operational Definitions
				moment prompts, or activities that require immediate emotional or cognitive engagement.
			Advice	Definition: The exchange of guidance or suggestions among group members or from the facilitator to the participants. Operational Definition: Instances were giving and receiving of advice was noted amongst group members or the facilitator.
			Social skills practice	Definition: The use of group interactions to develop and refine interpersonal skills such as communication, empathy, and conflict resolution. Operational Definition: Specific activities or exercises that allowed for the opportunity to practice social skills, such as group discussions, role-playing, or collaborative tasks/teamwork that require effective communication and interaction.

Additional codes added

Table 6.2: A Table revealing the additional codes from inductive coding

	Code Category with Definition	Concept Breakdown	Additional Codes	Definitions and Operational Definitions
Additional codes	Self-Agency	The capacity to make independent choices and take intentional actions that shape one's life, reflecting a sense of control, responsibility, and empowerment over personal decisions and outcomes.	Personal responsibility	Definition: Personal responsibility involves recognising and accepting one's role in their own growth, choices, and actions, often with a focus on accountability for outcomes. Operational Definition: Evident when participants acknowledge their role in making progress, demonstrate accountability for their decisions, or take steps that reflect ownership of their personal or recovery journey.
			Confrontation	Definition: Confrontation is a direct or challenging interaction that prompts individuals to face aspects of themselves or their situation that may require change, growth, or self-reflection. Operational Definition: Observed when participants or facilitators challenge each other's beliefs, attitudes, or behaviours constructively, often leading to moments of insight, self-reflection, or reassessment of goals.
			Change	Definition: Change refers to the process of transformation or development in thoughts, behaviours, or emotional responses, typically aimed at improving one's circumstances or personal growth. Operational Definition: Evident when participants describe shifts in their perspectives, behaviours, or attitudes over time, indicating personal growth, adaptation, or progress in their mental health journey.
	Synergy of the therapeutic program	Other treatment interventions, the hospital environment, and interactions during admission influence MHCUs' experience by either complementing or hindering their progress in recovery.	Synergy	Definition: The combined effect of various therapeutic components such as individual interventions, group therapies, skills, hospital environment, and individual experiences that interact to support or hinder the recovery during admission. Operational Definition: Mentions of other skills, interventions, interactions, experiences that complemented, detracted or was separate from the OTIGM intervention.

	Duality		Duality	Definition: The conflicting experiences and evolving perceptions participants have towards the group therapy process, where the group is seen as both helpful and challenging, and ideas about its value shift over time. Operational Definition: Noted when participants describe experiencing both benefits and difficulties throughout the group sessions, such as feeling supported and gaining insights, but also facing resistance or discomfort and views of the group evolving as the sessions progress.

APPENDIX O: Data Analysis sorting codes

Initial phases of planning

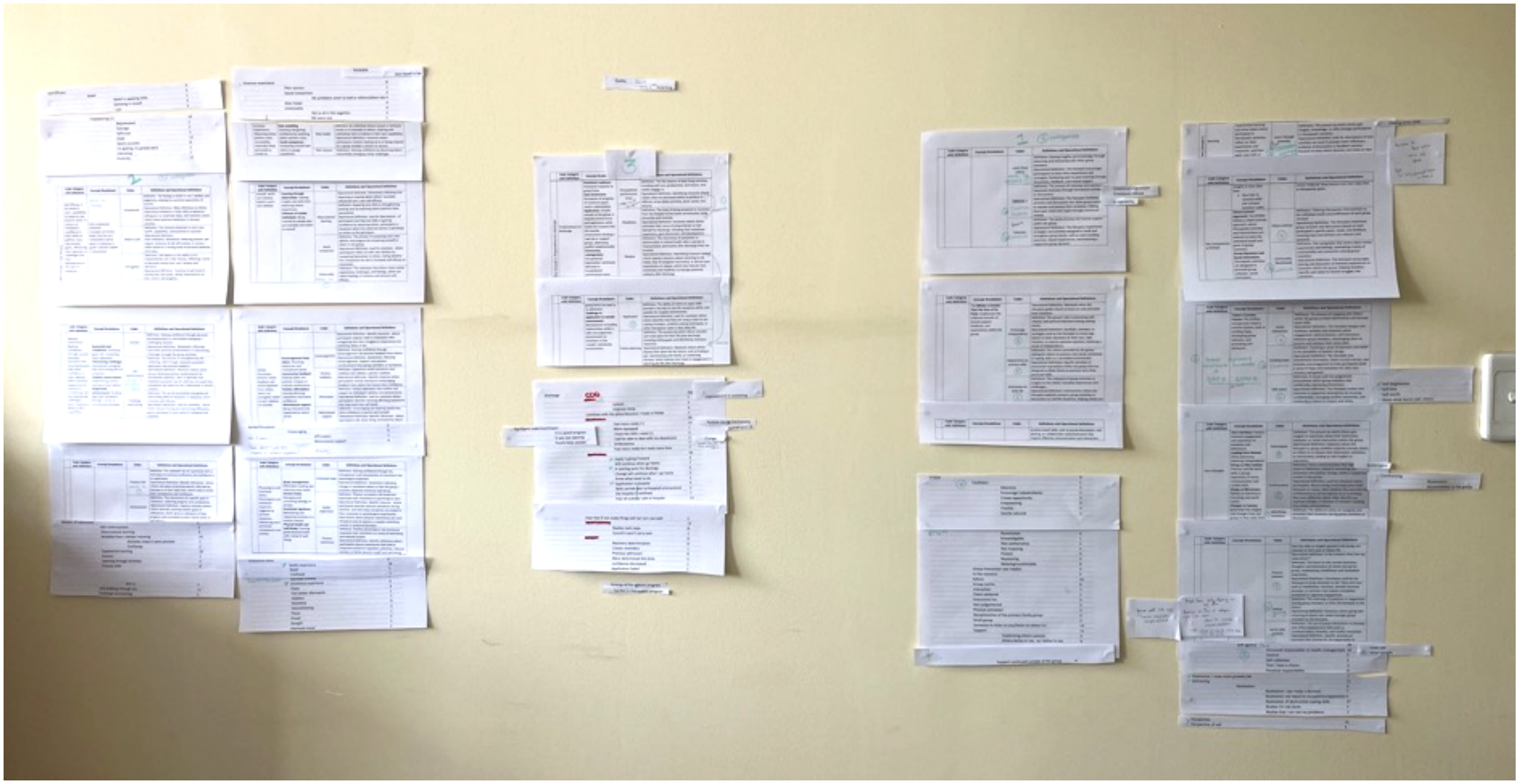


Figure 6.1: Initial planning exploring the predetermined codes and the additional codes sorted into the three predetermined themes

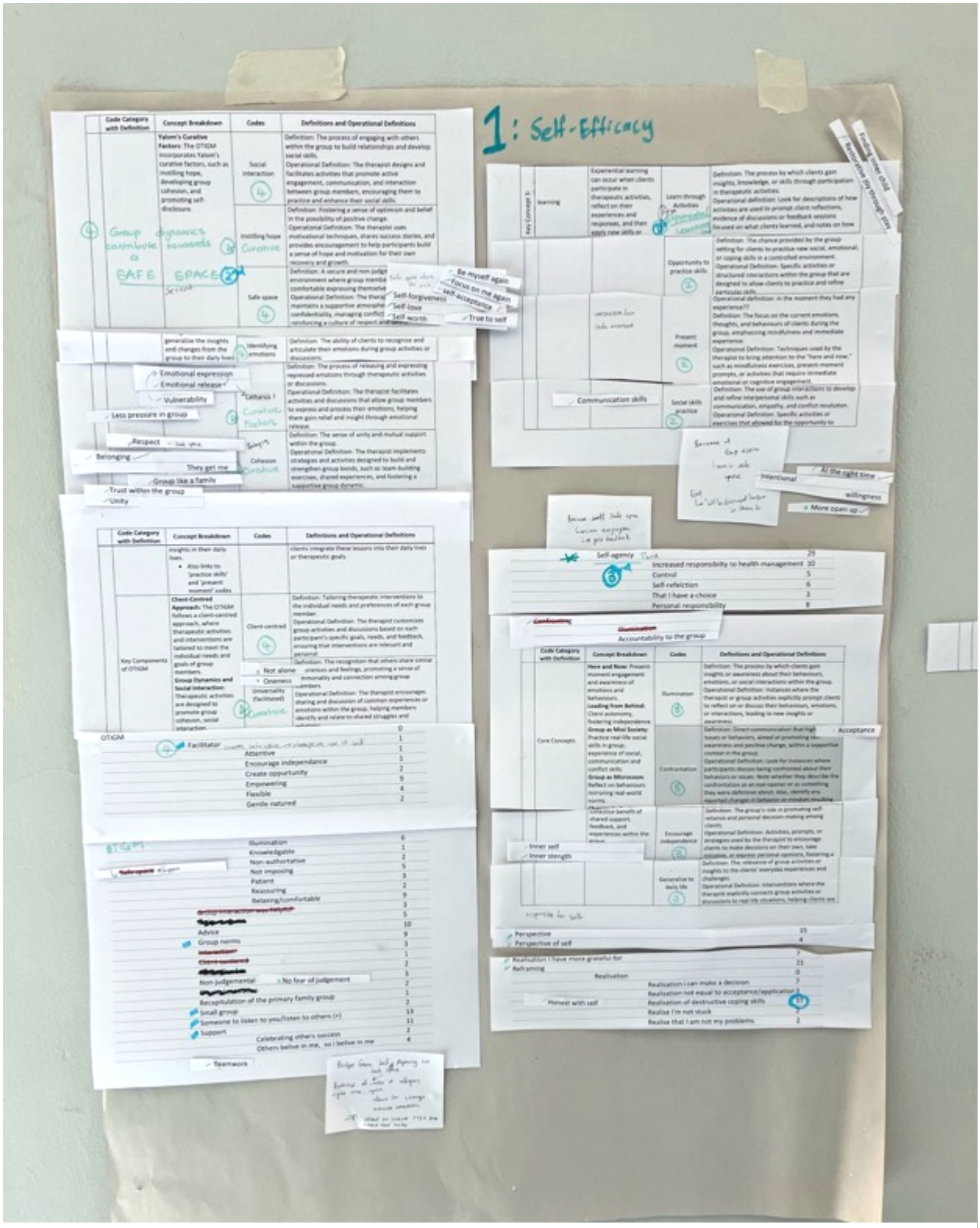


Figure 6.2: Refinement of sorting, indicating flow and sequencing of codes for theme 1

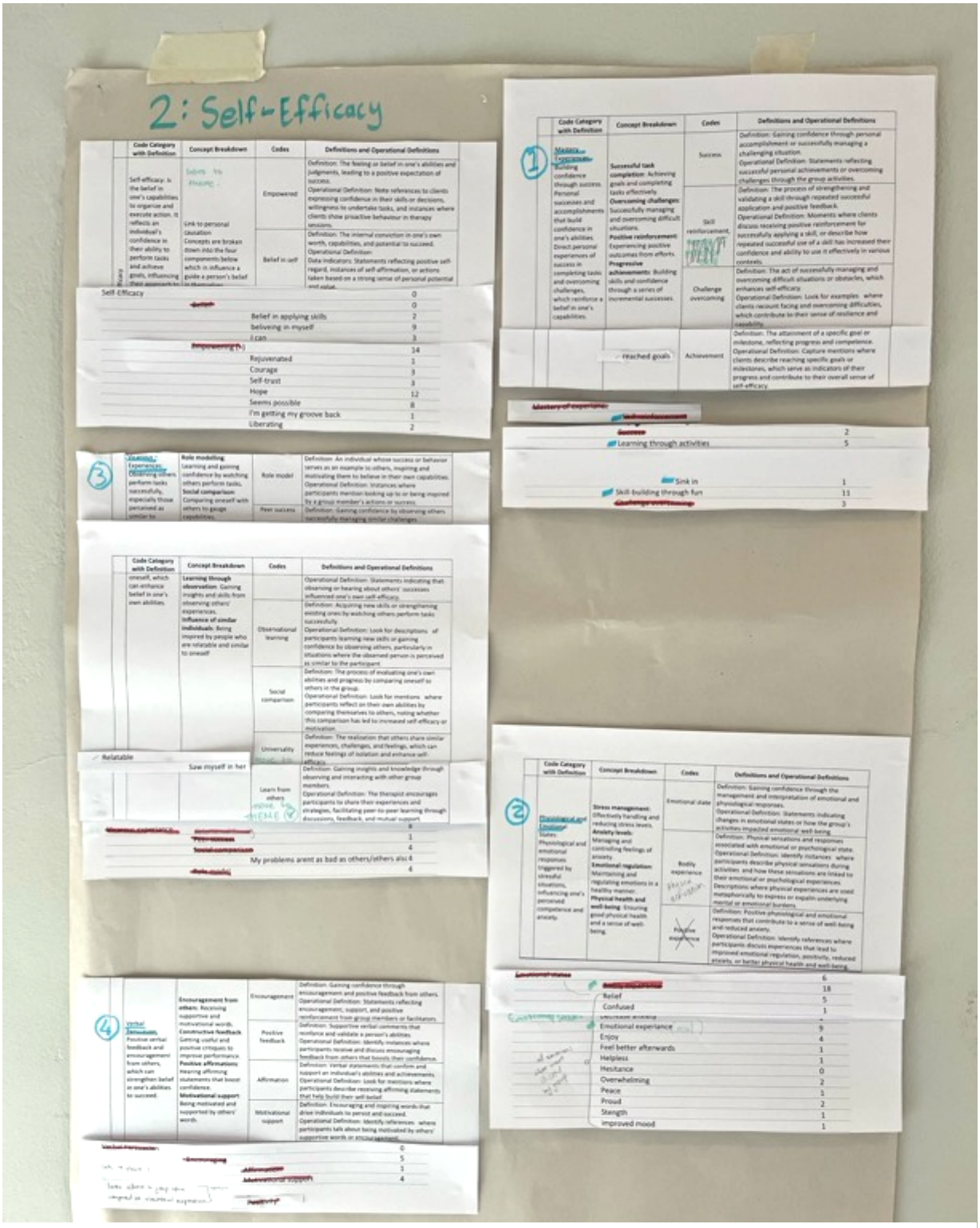


Figure 6.3: Refinement of sorting, indicating flow and sequencing of codes for theme 2

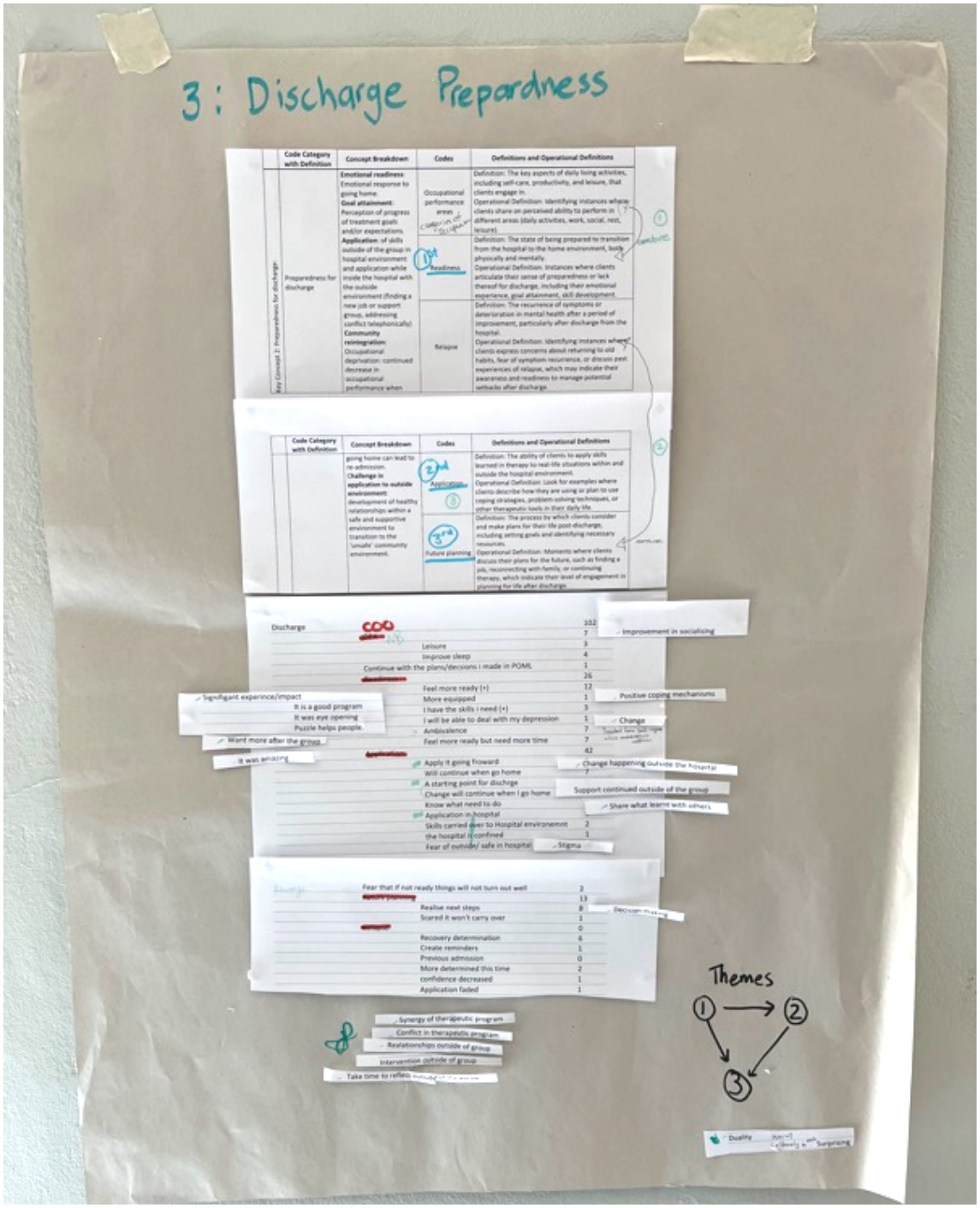


Figure 6.4: Refinement of sorting, indicating flow and sequencing of codes for theme 3.

Also acknowledges overall key codes for synergy of the therapeutic program and duality

APPENDIX P: Final categories and codes on MaxiMaps

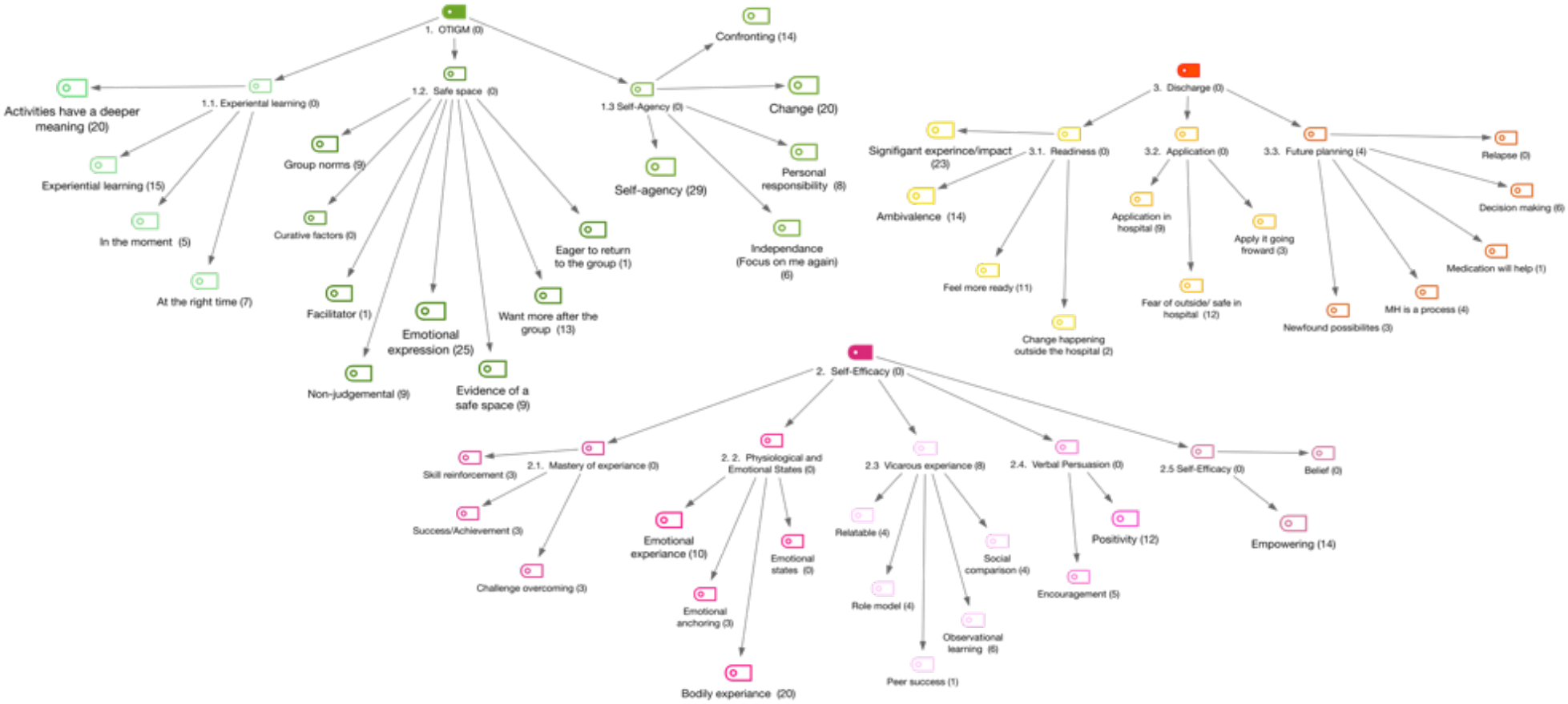


Figure 6.5: a Mind map generated in MaxiMaps feature in MAXQDA software which reflects the categories and key codes of each one.

APPENDIX Q: Final Codebook

Code	Frequency
1 1. **OTIGM**	
1.1 1.1. Experiential learning	*0*
1.1.1 Activities have a deeper meaning	20
1.1.1.1 Learning through activities	5
1.1.1.2 Skill-building through fun	13
1.1.1.2.1 Restorative joy through play	4
1.1.1.3 Confusing	2
1.1.2 Experiential learning	15
1.1.2.1 Finding inner child	4
1.1.2.2 Group vs individual	2
1.1.3 In the moment	5
1.1.4 At the right time	7
1.1.4.1 Loved ones as catalyst	1
1.1.4.2 More open/ able to open up	6
1.1.4.3 willingness	8
1.1.4.4 Intentional	2
1.2 1.2. Safe space	*0*
1.2.1 Group norms	9
1.2.1.1 Respect	1
1.2.2 Curative factors	0
1.2.2.1 Emotional release (Catharsis)	6
1.2.2.2 Interpersonal learning	3
1.2.2.2.1 Advice	10
1.2.2.3 Instilling hope	12
1.2.2.3.1 Others believe in me, so I believe in me	4
1.2.2.3.2 Seems possible	9
1.2.2.4 Universality	4
1.2.2.4.1 Not alone	8
1.2.2.4.2 We're all in this together.	3
1.2.2.4.2.1 Oneness	2
1.2.2.5 Cohesion (belonging)	3
1.2.2.5.1 Relationship building	1
1.2.2.5.1.1 Socialising more	1
1.2.2.5.1.1.1 Different types of people	1

Code	Frequency
1.2.2.5.1.2 Small group	2
1.2.2.5.1.3 Someone to listen to you/listen to others (+)	13
1.2.2.5.2 Cohesion	6
1.2.2.5.3 Unity	1
1.2.2.5.3.1 Teamwork	7
1.2.2.5.3.1.1 Social Interaction	3
1.2.2.5.3.2 Trust within the group	3
1.2.2.5.3.3 Vulnerability	21
1.2.2.5.4 Group like a family	2
1.2.2.5.4.1 Celebrating others success	2
1.2.2.5.4.2 Recapitulation of the primary family group	1
1.2.2.5.5 They get me	1
1.2.3 Facilitator	1
1.2.3.1 Client-centred	1
1.2.3.2 Attentive	1
1.2.3.3 Encourage independence	1
1.2.3.4 Create opportunity	2
1.2.3.5 Empowering	9
1.2.3.6 Flexible	4
1.2.3.7 Gentle natured	2
1.2.3.8 Illumination	6
1.2.3.9 Knowledgeable	1
1.2.3.10 Non-authoritative	2
1.2.3.11 Not imposing	5
1.2.3.12 Patient	3
1.2.3.13 Reassuring	2
1.2.3.14 Relaxing/comfortable	9
1.2.4 Non-judgemental	9
1.2.4.1 Less pressure in group	1
1.2.5 Emotional expression	25
1.2.5.1 Identifying emotions	2
1.2.6 Evidence of a safe space	9
1.2.6.1 True to self	4
1.2.6.2 Self-acceptance	3
1.2.6.2.1 Self-awareness	7
1.2.6.2.2 Self-forgiveness	1

Code	Frequency
1.2.6.2.3 Self-love	12
1.2.6.2.4 Self-worth	3
1.2.6.3 Be myself again	10
1.2.6.3.1 I'm getting my groove back	1
1.2.6.3.2 Align	2
1.2.7 Want more after the group	13
1.2.8 Eager to return to the group	1
1.3 Self-Agency	*0*
1.3.1 Self-agency	29
1.3.2 Independence (Focus on me again)	6
1.3.2.1 Inner self	3
1.3.2.2 Honest with self	3
1.3.2.3 Inner strength	2
1.3.3 Confronting	14
1.3.3.1 Self-reflection	6
1.3.3.1.1 Perspective	16
1.3.3.1.1.1 Perspective of self	5
1.3.3.1.1.2 More mindful of others/considerate	5
1.3.3.1.2 Acceptance	10
1.3.3.2 Reframing	21
1.3.3.2.1 Realisation	0
1.3.3.2.1.1 Realisation i can make a decision	7
1.3.3.2.1.2 Realisation I have more grateful for	7
1.3.3.2.1.3 Realisation not equal to acceptance/application	3
1.3.3.2.1.4 Realisation of destructive coping skills	37
1.3.3.2.1.5 Realise I'm not stuck	2
1.3.3.2.1.6 Realise that I am not my problems	2
1.3.3.3 Illumination	4
1.3.3.4 Accountability to the group	3
1.3.4 Personal responsibility	8
1.3.4.1 That I have a choice	3
1.3.4.2 Control	5
1.3.5 Change	20
2 2. **Self-Efficacy**	0
2.1 2.1. Mastery of experience	*0*
2.1.1 Skill reinforcement	3

Code	Frequency
2.1.1.1 Practice skills	8
2.1.1.1.1 Communication skills	11
2.1.1.2 Sink in	1
2.1.2 Success/Achievement	3
2.1.3 Challenge overcoming	3
2.2 2. 2. Physiological and Emotional States	*0*
2.2.1 Emotional experience	10
2.2.2 Emotional anchoring	3
2.2.3 Bodily experience	20
2.2.4 Emotional states	0
2.2.4.1 Enjoy	5
2.2.4.2 Happy	2
2.2.4.3 Proud	3
2.2.4.4 Relief	9
2.2.4.5 Peace	5
2.2.4.6 Anxious	2
2.2.4.7 Overwhelming	4
2.3 2.3 Vicarious experience	*8*
2.3.1 Relatable	4
2.3.1.1 Saw myself in her	2
2.3.2 Role model	4
2.3.3 Peer success	1
2.3.4 Observational learning	6
2.3.5 Social comparison	4
2.3.5.1 My problems aren’t as bad as others/others also have problems	4
2.4 2.4. Verbal Persuasion	*0*
2.4.1 Positivity	12
2.4.2 Encouragement	5
2.4.2.1 Positive Feedback	10
2.4.2.2 Motivational support	7
2.5 2.5 Self-Efficacy	*0*
2.5.1 Empowering	14
2.5.1.1 Self-advocacy	8
2.5.1.2 Courage	3
2.5.1.3 Self-trust	3
2.5.1.4 Liberating	2
2.5.2 Belief	0

Code	Frequency
2.5.2.1 Belief in applying skills	2
2.5.2.2 believing in myself	9
2.5.2.2.1 I can	3
3 3. **Discharge**	0
3.1 3.1. Readiness	*0*
3.1.1 Significant experience/impact	23
3.1.1.1 Letting go	7
3.1.2 Ambivalence	14
3.1.2.1 Fear that if not ready things will not turn out well	2
3.1.3 Feel more ready	11
3.1.4 COO	0
3.1.4.1 Improvement in socialising	4
3.1.4.2 Increased responsibility to health management	10
3.1.4.3 Leisure	3
3.1.4.4 Improve sleep	4
3.1.5 Positive coping mechanisms	12
3.1.5.1 More than medication	2
3.1.5.2 I have the skills i need	5
3.1.6 Change happening outside the hospital	2
3.2 3.2. Application	*0*
3.2.1 Application in hospital	9
3.2.1.1 Support continued outside of the group	4
3.2.1.2 Skills carried over to Hospital environment	2
3.2.2 Fear of outside/ safe in hospital	12
3.2.2.1 Stigma	5
3.2.2.2 Need to still practice when I go home	2
3.2.2.3 Scared it won’t carry over	1
3.2.3 Apply it going forward	3
3.2.3.1 Will continue when go home	10
3.2.3.2 Share what learnt with others	4
3.2.3.3 A starting point for discharge	12
3.2.3.3.1 Realise next steps	8
3.3 3.3. Future planning	*4*
3.3.1 Newfound possibilities	3
3.3.2 MH is a process	4
3.3.3 Medication will help	1
3.3.4 Decision making	6

Code	Frequency
3.3.5 Relapse	0
3.3.5.1 Recognise Symptoms	1
3.3.5.2 Recovery determination	7
3.3.5.3 Create reminders	1
3.3.5.4 Previous admission	0
3.3.5.4.1 More determined this time	3
3.3.5.4.2 confidence decreased	1
3.3.5.4.3 Application faded	1
4 Synergy of therapeutic program	*13*
4.1 Relationships outside of group	2
4.2 Intervention outside of group	2
4.3 Take time to reflect outside of the group	1
4.4 Conflict in therapeutic program	1
5 Duality	*24*
5.1 Surprising	3
6 Paraphrases	0

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APPENDIX R: Ethical clearance

UNIVERSITY OF THE WITWATERSRAND, JOHANNESBURG

R14/49 Miss Charis Papageorgiou

HUMAN RESEARCH ETHICS COMMITTEE (MEDICAL)

CLEARANCE CERTIFICATE NO. M240108 M240417-A-0001

NAME: (Principal Investigator)	Miss Charis Papageorgiou
DEPARTMENT:	Occupational Therapy CL Stander and Associates Occupational Therapy Practice
DEGREE:	MSc in Occupational Therapy
PROJECT TITLE:	*Exploring how Occupational Therapy Interactive Group intervention develops self-efficacy to impact discharge preparedness in clients with depressive disorders at a private acute inpatient psychiatric setting in South Africa: a mixed methods study*
DATE CONSIDERED:	26/01/2024
DECISION:	Approved unconditionally
CONDITIONS:	
NOTE:	HREC (Medical) Application Number: MED23-11-033
SUPERVISOR:	Miss J. Paruk and Mrs I. Tsatsi-Mosala
APPROVED BY:	Professor Paul Ruff, Chairperson, HREC (Medical)
DATE OF APPROVAL: 17/04/2024	**EXPIRY DATE:** 17/04/2029

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

DECLARATION OF INVESTIGATOR(S)

I/we fully understand the conditions under which I am/we are authorized to carry out the abovementioned 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** in the month date of convened meeting each year until study is closed. Failure to submit annual report will result in ethics clearance certificate suspension. The date for annual re-certification will be one year after the date of convened meeting where the study was initially reviewed. Unreported changes to the application may invalidate the clearance given by the HREC (Medical). Login to upload signed copy of this ethics clearance certificate prior to commencing with the study https://www.witsethics.co.za/login.aspx. Email a signed copy of ethics clearance certificate to HREC-Medical.ResearchOffice@wits.ac.za.

Principal Investigator Signature

17/04/2024
Date

APPENDIX S: Turn It In

Dissertation 18 March 2025

ORIGINALITY REPORT

6%	4%	5%	1%
SIMILARITY INDEX	INTERNET SOURCES	PUBLICATIONS	STUDENT PAPERS

PRIMARY SOURCES

1	Submitted to Harper Adams University College Student Paper	<1%
2	Meyer, Annalie Francina. "Change in Activity Participation of Mental Health Care Users with Major Depressive Disorder Attending Occupational Therapy Groups", University of the Witwatersrand, Johannesburg (South Africa), 2025 Publication	<1%
3	worldwidescience.org Internet Source	<1%
4	wiredspace.wits.ac.za Internet Source	<1%
5	Janine Clarke, Judith Proudfoot, Mary-Rose Birch, Alexis E Whitton et al. "Effects of mental health self-efficacy on outcomes of a mobile phone and web intervention for mild-to-moderate depression, anxiety and stress: secondary analysis of a randomised controlled trial", BMC Psychiatry, 2014 Publication	<1%
6	www.coursehero.com Internet Source	<1%
7	pmc.ncbi.nlm.nih.gov Internet Source	<1%
8	Rosemary Crouch. "Occupational Group Therapy", Wiley, 2021	<1%