TOWARDS CLIENT-CENTRED PRACTICE WITHIN AN OCCUPATIONAL THERAPY GROUP LIFE SKILL PROGRAM: AN ACTION RESEARCH JOURNEY

by

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DECLARATION

I hereby declare that the dissertation entitled

"TOWARDS CLIENT-CENTRED PRACTICE WITHIN AN OCCUPATIONAL THERAPY GROUP LIFE SKILL PROGRAM: AN ACTION RESEARCH JOURNEY."

submitted for the qualification Magister in Occupational Therapy at the University of the Free State, is my independent work. I declare that I have not previously submitted the same work for a qualification at another university. I hereby concede copyright to the University of the Free State.

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Esna Carroll

"As recovery belongs to people with psychiatric disabilities,
and as it is up to them to define what it is and what it entails,
it is key that people in recovery lead the way"

(Davidson, Kirk, Rockholz, Tondora, O'Connell & Evans 2007:23).

I dedicate this work to:

All the clients who have attended my occupational therapy life skill groups throughout the years.

I have learned a tremendous amount from you. I admire you for having had the courage to deal with your illness and address the problems, heartache, trauma and challenges in your life. You make my daily work worth it.

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LIST OF ABBREVIATIONS

OT	Occupational therapist
PC	Private clinic
AR	Action research

DEFINITIONS AND CONCEPT CLARIFICATION

The following definitions and clarification of concepts are included to describe and explain words and concepts to the reader for orientation and to define the focus in this specific study. Some of the concepts are well-defined by a set definition, while others are further clarified to show the context in which it will be applied for this study.

Concept	Clarification
Action research (AR)	Action research (AR) is practical, focused on changed, a cyclical process, it involves participation and is an interactive form of knowledge development (Ebersöhn, Eloff & Ferreira 2007: 124). In this study the method pursued is Technical AR. Technical AR aims to "improve the effectiveness of practice" and "the practitioners is greatly dependant on the researcher as facilitator" of the process (Ebersöhn *et al*. 2007: 124). It also involve ethnographic features (Herr & Anderson 2005:24-25) as the researcher scrutinise her own practice to ensure that she evolve her skills to be more client-centred when presenting life skills within a set program with pre-determined themes. Stakeholders only participate in the AR process while in-patients at the clinic (i.e. in one of the AR cycles) and are valuable contributors as a participatory AR approach was not viable in this setting.
Attitude	"A way of thinking" (Oxford English Dictionary & Thesaurus 2009:54). In this study, attitude implies a participant's approach to, outlook on and view of a certain subject, situation or person.
Best practice	"Best possible practice as a result of evidence-based, reflexive or reflective practice" (Blair & Robertson 2005:270). My understanding of best practice is aptly described by Parker (2011:139) as she states that client-centred care is considered the optimum way to provide health care. In this study client-centred practice is seen as best practice. Thus in order to attain best practice youre practice has to be client-centred. The focus of the study in order to attain best-practice would therefor be to explore if my facilitation of groups is client-centred or how to change groups during the course of the cycles to be more client-centred. Thus reflective and reflexive practice provides the support in order to attain client-centred practice.
Client	In this study, "client" will refer to patients in general admitted to the private clinic (PC). These patients are not part of the researcher's occupational therapy life skill groups or have not yet joined the groups.
Client-centred practice	"Collaborative and partnership approaches used in enabling occupation with clients who may be individuals, groups, agencies, governments, corporations or others: Client-centred occupational therapists demonstrate respect for clients, involve clients in decision making, advocate with and for clients' needs, and otherwise recognise clients' experience and knowledge" (Townsend, Stanton, Law, Polatajko & Baptiste 2002:80). "Client-centred practice is a process in which occupational therapy revolves around the client as the focal point of intervention" (Parker 2011:139).

Concept	Clarification
Co-coders	The role of the co-coders in this study is to also analyse the reflections and questionnaires of stakeholders in order to identify themes. The two co-coders are a colleague (occupational therapist) in the same practice with five years' experience in the presentation of life skill groups, a Master's degree, and experience in qualitative research and thematic coding; the other is also an OT and a lecturer at the Department of Occupational Therapy at the University of the Free State, with experience in mental health, a Master's degree and experience in qualitative research.
Context	"The relationship between the environment, personal factors and events that influence the meaning of a task, activity or occupation for the performer" (Creek 2010:25).
Critical friend	According to McNiff, Lomax and Whitehead (1996:77) "AR is about sharing ideas, interpretations and conclusions with an 'educated' audience who are able and willing to judge the authenticity and relevance of the work to a particular professional extent." The critical friend in this study is an OT with a great deal of knowledge and expertise in mental health and experience in occupational therapy groups within a sub-acute mental health setting. She is at present a lecturer at the Department of Occupational Therapy at the University of the Free State. The role of the critical friend would be as described above: to give critical feedback on the study.
Enablement	"The process of helping the client to identify what is important to him, set his own goals and work towards them, thus taking more control of his life" (Creek & Lougher 2008:580). Enablement in this study does not refer to reaching long term goals, but focuses on the immediate knowledge that stakeholders gained. It focuses on what specific life skills stakeholders felt they would be able to apply and also their motivation to apply these life skills that they have mastered, in future. Therefore, enablement in this sense refers to how participation in the life skills program supports stakeholders to make the most of the opportunities during their rehabilitation as a first step towards taking control of their lives.
Exploration	"Examine or discuss something in detail. Investigate" (Oxford English Dictionary & Thesaurus 2009:328). In this study, exploration refers to the method through which insight regarding the occupational therapy life skill program was gained. The exploration was done mainly by reflexion and observation from the outsider (OT) and reflexion from the insiders (clients/stakeholders).
External indicators	In this study, external indicators refer to factors not directly associated with the group process that I am involved in, and which I do not have any control over, e.g. client's side-effects experienced due to medication and the interruption of groups by other team members.
Facilitation	In this study, facilitation refers to all actions taken by the researcher within or related to the planning and presentation of life skill groups. Actions of facilitation might include, for example, explanation of the group program to a potential stakeholder, preparing the group therapy room with regard to positioning of furniture, as well as the actual presentation of the life skill group session.

Concept	Clarification
Group-based intervention	"The deliberate gathering of three or more persons in order to create change for the members" (Cara & MacRae 2005:530).
Group	In this study, a group refers to a number of clients attending the set psycho-social group therapy program for a period of two weeks (when mentioning a group within the specific study it means that the group is facilitated by myself).
Internal indicators	In this study, internal indicators refer to factors directly associated with the group process that I am involved in, for example my facilitation of the overall group process and presentation of the group session.
Knowledge	"Information and awareness gained through experience or education. The state of knowing about something" (Oxford English Dictionary & Thesaurus 2009:517). For the purposes of the study, knowledge will refer to a participant's comprehension and realisation regarding a certain theme or subject.
Life skills	"Skills enable people to operate as individuals and contribute to their functioning as part of the society in which they belong." (Creek & Lougher 2008:360). "Psycho-social life skills are a group of skills based on behaviour, cognition and interaction. Affective and anxiety disorders may be associated with life skill deficits, which become the focus of occupational therapy intervention in order to enable the client to function at an optimal level" (Roberts 2008: 364-368). In this study life skills refer to skills in the program presented to clients by an occupational therapist within the set psycho-social group therapy program. These skills include stress management, assertiveness and setting boundaries, addressing anxiety, promoting a healthy self-image, social interaction and communication skills, and conflict management.
Participation	"Involvement in life situations through activity within a social context" (Creek 2010:26).
Potential stakeholders	Potential stakeholders in this study suggest clients who could join the researchers' occupational therapy life skill groups, but who have not (yet) consented to being a part of the study.
Satisfaction	"The feeling of pleasure that arises when you have the things you need, or want, or when the things you want to happen, have happened" (Oxford English Dictionary & Thesaurus 2009:822). In this study, satisfaction indicates the approval and contentment of stakeholders regarding the life skill program.
Skill	"An ability developed through practice which enables effective occupational performance" (Creek 2010:26). In this study, skill suggests the ability of a participant to apply the knowledge that he/she has gained or the prospect of being able to utilise the knowledge of the skill in the future to enable effective occupational performance.
Stakeholders	Dick (2002:3) explains that stakeholders are "people who are directly affected by what is happening or what is going to happen, anyone affected by a change or able to affect it." As clients attending the OT's life skill group are an integral part of what is happening during the therapy process (and therefore within the AR process), it would have an impact on not only future groups, but current insights would depend on input from clients. Therefore, stakeholders refer to clients who joined the researcher's occupational therapy life skill groups after giving informed consent to be a part of the study.

SUMMARY

The aim of this study was to explore how I could gain insight into my current facilitation of a predetermined/structured two-week life skill program in order to continually address client-centred practice for the clients I serve. This study was conducted at a private psychiatric clinic (PC) in the Free State, South Africa. I cultivated personal reflexivity in order to gain a greater understanding/insight of how external indicators and internal indicators influenced the life skill program, and also explored what the effect of the life skill program on clients was; this all took place in collaboration with my clients, making them stakeholders in the study.

This study/exploration was undertaken as some clients had returned to the clinic after having attended the occupational therapy life skill program at their previous admittance to the PC, but still experienced problems with life skills. I thus wanted to establish whether I was attaining best practice with the clients I serve while they were admitted and in the life skill groups I facilitated. My understanding of best practice is aptly described by Parker (2011:139) as she states that client-centred care is considered the optimum way to provide health care. In order to explore if I was attaining best-practice, I had to explore if my facilitation of life skill groups were client-centered and also which other factors influenced their experience of the life skill groups. All the above mentioned questions as well as a disparity in terms of relevant research-based findings (as mentioned further in the summary) called for evidence based practice in order to attain client-centred practice for the clients I serve. Thus reflective and reflexive practice provides the support in order to attain client-centred practice.

South African literature on occupational therapy group practice in mental health settings are limited, but suggest similar programs for people diagnosed with mood and anxiety disorders, albeit without specific guidelines as to the facilitation of these groups in the context of a sub-acute psychiatric clinic within a South African setting.

As I wanted to gain insight into the life skill groups I presented and the stakeholders' experience thereof, a study with an explorative nature using Action Research (AR) with a multiple-method approach was conducted. I used mainly qualitative elements in daily reflection activities for stakeholders and for myself, as well as some quantitative elements such as checklists as the methods of data collection.

In this study, the population (stakeholders) consisted of clients who attended the Afrikaans group program at the psychiatric clinic, after being admitted to the PC by a psychiatrist. The stakeholders included male and female clients older than 18 years, with various differing mental health diagnoses, of which mood- (depressive) and anxiety disorders were most common. The number of potential stakeholders in a group in one cycle would generally range between five to 12 people.

A multifaceted thematic analysis was used for the qualitative data. I analysed the data, together with two co-coders. Quantitative data analysis was completed by the Department of Biostatistics, UFS, after I had entered data using Microsoft Excel and had a co-coder verify. A "critical friend" also helped me gain perspective in the study.

Findings described the stakeholders' and my own experience of the life skill groups and highlighted the indicators that had a negative and positive influence on experiences. It also elaborated on the effect the life skill groups had on stakeholders, thus the client-centredness of these groups, and satisfaction of stakeholders. Throughout the AR process, changes were made according to the findings in order to continually address client-centredness and thus best practice for the stakeholders in my groups.

The findings as well as the role of the AR process were further integrated and discussed, using the client-centred frame of reference as background for the discussion.

In the closing, conclusions and recommendations towards client-centred practice were made comprising internal and external indicators against the framework of client-centredness. These recommendations included acknowledging and discussing suggestions on the limitations of the study, and recommendations for future research were offered.

OPSOMMING

Die doelwit van hierdie studie was om te verken hoe ek insig kon verkry van my huidige fasilitering van 'n voorafopgestelde/gestruktureerde twee weke lange lewensvaardigheidprogram ten einde deurlopend kliëntgesentreerde praktyk aan te spreek vir die kliënte wat ek bedien. Die studie was by 'n private psigiatriese kliniek (PC) in die Vrystaat, Suid-Afrika, uitgevoer. Ek het persoonlike refleksie gekultiveer ten einde 'n beter begrip/insig te verkry oor hoe eksterne indikators en interne indikators die lewensvaardigheidprogram beïnvloed, en ek het ook verken wat die uitwerking van die lewensvaardigheidprogram op kliënte was; dit het alles in samewerking met my kliënte plaasgevind, wat hulle belanghebbendes in die studie gemaak het.

Hierdie studie/verkenning was onderneem aangesien sommige kliënte na die kliniek teruggekeer het nadat hulle die arbeidsterapie-lewensvaardigheidprogram ten tyde van hul vorige opname by die PC bygewoon het, maar steeds probleme met lewensvaardighede ervaar het. Ek wou dus vasstel of ek die beste praktyk verkry met die kliënte wat ek bedien het ten tyde van hul opname en in die lewensvaardigheidsgroepe was wat ek gefasiliteer het. My begrip van beste praktyk is gepas beskryf deur Parker (2011:139), aangesien sy noem dat kliëntgesentreerde sorg as die optimale manier beskou word om gesondheidsorg te voorsien. Ten einde te verken of ek beste praktyk behaal het, moes ek verken of my fasilitering van lewensvaardigheidsgroepe kliëntgesentreerd was en ook watter ander faktore hul ervaring van die lewensvaardigheidsgroepe beïnvloed het. Al bogenoemde vrae, asook 'n teenstrydigheid in terme van relevante navorsingsgebaseerde bevindinge (soos verder in die opsomming genoem), het bewysgebaseerde praktyk ten einde kliëntgesentreerde praktyk te verkry vir die kliënte wat ek bedien, vereis. Reflektiewe en refleksiewe praktykvoering het dus die ondersteuning gebied om kliëntgesentreerd in my groepe te bevorder.

Suid-Afrikaanse literatuur oor arbeidsterapie-groeppraktyk in geestesgesondheidsomgewings is beperk, maar stel soortgelyke programme vir mense gediagnoseer met gemoeds- en angsversteurings voor, ofskoon sonder spesifieke riglyne vir die fasilitering van hierdie groepe in die konteks van 'n sub-akute psigiatriese kliniek binne 'n Suid-Afrikaanse opset.

Aangesien ek insig oor die lewensvaardigheidsgroep wat ek aanbied en die belanghebbendes se ervaring daarvan wou verkry, is 'n studie van 'n verkennende aard uitgevoer deur aksienavorsing ("action research"; AR) met 'n veelvuldige metode-benadering te gebruik. Ek het hoofsaaklik kwalitatiewe elemente soos daaglikse refleksie-aktiwiteite vir belanghebbendes en myself gebruik, asook 'n paar kwantitatiewe elemente soos kontrolelyste as metodes van dataversameling.

In hierdie studie het die populasie (belanghebbendes) bestaan uit kliënte wat die Afrikaanse groepprogram by die psigiatriese kliniek bygewoon het nadat hulle deur 'n psigiater by die PC opgeneem is. Die belanghebbendes het ingesluit manlike en vroulike kliënte ouer as 18 jaar, met verskillende geestesgesondheidsdiagnoses, waaronder gemoeds- (depressiewe) en angsversteurings die mees algemeen was. Die hoeveelheid potensiële belanghebbendes in 'n groep in een siklus was in die algemeen tussen vyf en 12 mense.

'n Veelsydige tematiese analise is vir die kwalitatiewe data gebruik. Ek het die data geanaliseer, tesame met twee medekodeerders. Kwantitatiewe data-analise is deur die Departement Biostatistiek, UV, voltooi nadat ek data ingelees het d.m.v. Microsoft Excel en dit deur 'n medekodeerder laat verifieer het. 'n "Kritiese vriend" het my ook gehelp perspektief kry binne die studie.

Bevindinge beskryf die belanghebbendes se en my eie ervarings van die lewensvaardigheidsgroep en het die indikators wat 'n negatiewe en positiewe invloed op ervarings gehad het, aangedui. Dit het ook uitgebrei op die uitwerking wat die lewensvaardigheidsgroepe op belanghebbendes gehad het; dus die kliëntgesentreerdheid van hierdie groepe, en tevredenheid van belanghebbendes. Regdeur die AR-proses is veranderinge aangebring volgens die bevindinge ten einde deurlopend kliëntgesentreerdheid, en dus beste praktyk vir die belanghebbendes in my groepe, aan te spreek.

Die bevindinge, asook die rol van die AR-proses, is verder geïntegreer en bespreek deur die kliëntgesentreerde verwysingsraamwerk as agtergrond vir die bespreking te gebruik.

In die slot is gevolgtrekkings en aanbevelings vir beste kliëntgesentreerde praktyk gemaak, wat bestaan uit interne en eksterne indikators gesien in die lig van die raamwerk van kliëntgesentreerdheid. Hierdie aanbevelings sluit in die erkenning en bespreking van voorstelle oor die beperkings van die studie, en aanbevelings vir toekomstige navorsing is voorgel

KEYWORDS

- Client-centred practice
- Occupational therapy
- Group program
- Life skill program
- Action research

CHAPTER 1
INTRODUCTION AND ORIENTATION

1.1 INTRODUCTION AND BACKGROUND

Four and a half million people worldwide experience disorders of mental health or neurology (Creek & Lougher 2008:xi). South African data on the prevalence of major depressive disorder are limited. Between 2002 and 2004 a household survey was done using the World Health Organization Composite International Diagnostic interview (CIDI) to establish a diagnosis of depression. A sample of 4 351 adult South Africans of all racial groups presented with a 9.7% lifetime prevalence of major depression, and 4.9% for the 12 months prior to the interview (Tomlinson, Grimsrud, Stein, Williams & Myer 2009:367-373). In view of these statistics it seems that mental ill health is also a reality in South Africa. South Africans are diagnosed daily with mental health disorders and admitted to sub-acute psychiatric hospitals/clinics.

One of these private psychiatric clinics is situated in the central Free State and admits between 10 and 25 clients every week. The diagnoses for clients admitted to the clinic include the whole range of mental disorders, the most common disorders being mood and anxiety disorders. The clients are predominantly white and Afrikaans-speaking, hailing from the Free State, Northern Cape and North West province (Hospital statistics for the period June 2011 to June 2013).

After admission to the Private Clinic (PC), clients have the opportunity to attend a two-week psycho-social group therapy program. Groups are presented by psychologists, psychiatrists, dieticians, physiotherapists and occupational therapists. Clients with psychotic features, symptoms of substance withdrawal and cognitive impairment do not attend groups, and are offered intervention in individual sessions.

The occupational therapy group program consists of two to four group sessions a day, and includes life skill groups, creative activity groups and relaxation therapy. The topics addressed in the life skill groups are: stress management, self-knowledge, self-image, anxiety, assertiveness, and conflict handling. Within these topics, various sub-topics are attended to (cf. Table 2.2); however, the emphasis remains on the communication and interpersonal skills components addressed in all the life skill groups. An occupational therapist (OT) starts with a specific group of clients on the Monday of their arrival at the hospital and remains with this

group, accordingly presenting all the life skill group sessions for this group of clients over the two-week admission period.

At the time of commencement of the research project, I had been working as an OT in the described setting for two years. The contents of my group sessions were largely pre-determined as the topics, content and group presentation were part of a structured program.

Observations I made during the presentation of sessions, conversations with colleagues, and feedback from clients, led me to reflect on my own facilitation of occupational therapy life skill groups within the program. In addition, clients who were readmitted and who had already completed the two-week program reported continued problems in terms of "life skills" (for example that they still found it difficult to handle conflict or to be assertive).

Reflecting on my own practice within the given context of the hospital, I had to answer the unyielding question of whether I was attaining "best practice" with my facilitation of life skill groups, and if any changes could be made to better facilitate these group sessions. I consequently had to determine how I could gain insight into my current occupational therapy life skill groups, and what internal indicators/aspects (i.e. my facilitation of the overall group process and presentation of the group sessions) and external indicators/aspects (i.e. factors not directly associated with the group process I am involved in) influenced these groups in order for me to continually address best practice within the scope of occupational therapy for the clients I serve.

I then began thinking retrospectively about experiences with my previous life skill groups. To me, some aspects stood out as positive contributors towards the groups – but I also became aware of situations and factors that I saw as negative aspects influencing my groups. I also asked questions about my own role in these life skill groups and the topics presented in the groups. The mentioned observations and thoughts were based on my personal experience, and I had no basis for this. I actively sought a structured process to guide my reflections, and this REFLECT stage initiated engagement in an ongoing action research process – the inspiration for my research project and foundational phase for the first cycle of my study.

I identified the following factors as obstacles in my life skill groups (negative indicators):

- In the orientation group on Mondays, I met the group members who would be attending my groups for the next two weeks. As it was not possible to have individual interviews with members before the commencement of the psycho-social group program, or to read the individual files, I did not have any background information on these clients or why they had been admitted. I therefore found it more difficult to relate with clients, to be sensitive regarding certain subjects, or to use relevant examples in the groups. This usually improved as the week continued, as I got to know the clients in my group and had time to read the files, which often did contain some information.
- Some clients were not admitted in time on Mondays to attend the orientation session where they were not only orientated, but where group norms were agreed upon and where they were introduced to one another and the OT. Some clients joined the group later in the week, sometimes up to Wednesday, and this influenced the group dynamics.
- The interruption of groups when a member had to leave for another appointment, e.g. with a psychiatrist or psychologist.
- The fact that all group members could not be present in all the sessions due to various reasons (e.g. appointments, tests at other hospitals, side-effects of medication that caused a client to feel dizzy or sleepy), influenced the group dynamics or prohibited a group member from joining group discussions as he/she did not have relevant background information.
- A client's participation/experience of the group was influenced by their depression and anxiety or side-effects of medication, especially within the first few days of the program.
- A client's participation/experience of the group was influenced by factors outside of the group, such as personal worries.
- Some clients found it very difficult to function within a group due to social phobia or anxiety.
- The level of education of the clients influenced their participation in the group and their experience of the group.
- Clients' personalities differed, which influenced their participation in the group and their experience of the group.

I identified the following factors as being beneficial to my life skill groups (positive indicators):

- It seemed that the group sessions were more therapeutic when group dynamics were better.
- Clients in the group related with one another, felt some sense of belonging, and realised that other people also had hardships in life – that in itself helped the clients.
- It seemed that clients felt safe in the group.
- I found that activities, especially projective techniques, "opened-up" the group and made them share more and supported growth in the group, i.e. it enhanced the group process.
- I found that clients felt relieved after having had the opportunity to share in the group.
- I found that clients had renewed hope after completing the two-week program and expressed that they had attained skills to help them when they go home.

A question I also wondered about, as mentioned before, was if the topics of our life skill groups were relevant to the population we presented it to.

Topics in the occupational therapy program included stress management, self-knowledge, self-image, anxiety, assertiveness and conflict handling. Within these topics different sub-topics were attended to, with emphasis on communication skills throughout all the sessions, as mentioned before. South African literature (Crouch & Ahlers 2005; Duncan 2005:442; Van Greunen 1997:272-283) on occupational therapy group practice in sub-acute mental health settings are limited, but suggest similar programs for people diagnosed with mood and anxiety disorders, albeit without specific guidelines as to the facilitation of these groups in the South African setting. Other literature (Cara 2005:181; Hawkes, Johnstone & Yarwood 2008:403) also indicate that these topics are suitable occupational therapy goals for a population with mood and anxiety disorders; however, literature by Cara (2005:176) and Hawkes, Johnstone & Yarwood (2008:403) have been published in the United States of America (USA) and the United Kingdom (UK) respectively, and did not remark on the appropriateness of these topics for people in other countries.

Following the above-mentioned information, it was evident that I had to explore my current life skill groups to gain insight into which internal and external indicators influenced the occupational therapy life skill groups I facilitated, within the specific setting of the PC.

My understanding of best practice is aptly described by Parker (2011:139) as she states that client-centred care is considered the optimum way to provide health care. Law, Baptiste & Mills (1995:253) developed the original and well-known definition of client-centred practice in occupational therapy, which is also used in this study:

"Client-centred practice recognises the autonomy of individuals, the need for client choice in making decisions about occupational needs, the strengths clients bring to a therapy encounter, the benefits of client-therapist partnership and the need to ensure that services are accessible and fit the context in which the client lives".
(Law, Baptiste & Mills 1995:253).

I decided to also use the key concepts of client-centred care as initially identified by Law *et al.* (1995:250-258) as a guideline (theoretical frame of reference) when aiming to gain insight into my facilitation of life skill groups. These concepts include **autonomy/choice, partnership and responsibility, enablement, contextual congruence, accessibility** and **flexibility** (Law *et al.* 1995:250-258; Parker 2011:140-141).

It seemed that in order to move towards client-centredness and best practice, the client needed to be involved in the research process. The involvement of clients as stakeholders, rather than merely participants, would ensure that a collaborative effort with clients was utilised in order to gain better understanding of the occupational therapy life skills program (Bhana 2006:432). Dick (2002:4) advocates that "ultimately stakeholders are persons" and therefore they would be able to supplement as well as complement the researcher's (outsider) experience, due to their lived reality as insiders. An exploration of the above-mentioned internal and external indicators/aspects as well as the effect of the life skill groups on stakeholders from both an outsider's and insider's perspective, thus in collaboration with clients, would provide insight into describing and interpreting the life skill groups I present.

Renewed understanding would enable me to continually direct, guide and adapt my facilitation of life skill groups towards best client-centred practice within the context of the PC.

1.2 PROBLEM STATEMENT

The problem was identified as some clients who were readmitted and had already completed the two-week program, reported still having problems in terms of "life skills". I had to answer the unyielding question of whether I was attaining best practice in my occupational therapy life

skill groups and what the immediate effects of these groups (contents and facilitation) on clients were within the time of admittance.

Conversations with colleagues and observations I made during the facilitation of sessions further led me to reflect on my occupational therapy life skill groups. It guided me towards identifying aspects that I thought had a negative and positive influence on the clients' experience of the group (cf. 1.1). I questioned my own facilitative skills and whether the topics I presented were relevant to the clients I served. I had no evidence for the observations I made and accordingly had to explore which aspects were beneficial or obstacles to the therapeutic quality of the life skill groups I presented. I also had to explore the effect of my facilitation on the groups and if the topics presented in the groups were relevant.

Accordingly, I wanted to establish what changes could be made to improve these groups in order to meet clients' needs (thus be more client-centred) by using life skills as a tool in mental health. I thus had to determine how to make the most of the structured/predetermined group contents and structured setting to address the needs of individual group members, and so-doing attain best practice in my life skill groups. Thus: were my group sessions specific enough for clients to gain knowledge and skill towards enablement in the limited time frame.

Client-centredness had to be taken into account and I had to identify any changes that could be made to improve these groups. I had to find a way to direct, guide and adapt my facilitation of life skill groups towards client-centred practice, within the context of the PC. This challenge led me towards the research question.

1.3 RESEARCH QUESTION

How could I gain insight into my current facilitation of a predetermined/structured two-week life skill program to continually address client-centred practice for the clients I serve?

1.4 AIM OF THE STUDY

This study thus aimed to explore how I could gain insight into my current facilitation of a predetermined/structured two-week life skill program to continually address client-centred practice for the clients I serve.

1.4.1 Objectives

Utilise a collaborative effort with clients from both an insider and outsider perspective in order to:

1.4.1.1 Gain insight into how stakeholders perceive the contents and facilitation of the life skill program to support their individual needs during admittance (client-centredness of life skill program and enablement of stakeholders).

1.4.1.2 Cultivate personal reflexivity and gain a greater understanding/insight of how **external indicators** may influence the life skill program.

1.4.1.3 Cultivate personal reflexivity and gain a greater understanding/insight of how **internal indicators** may influence the life skill program.

1.5 METHODOLOGY

In order to fulfil the aim of the study, namely to explore the occupational therapy life skills program action research (AR) with a multiple-method approach was conducted, as the focus was on the **cyclical** nature of continuously evaluating, adapting and planning input (Ebersöhn, Eloff & Ferreira 2007:125-130). Mostly qualitative elements in daily reflection activities for stakeholders and the group presenter were used, as well as some quantitative elements such as checklists. Bassey (1995:6) states that the action researcher's aim is to describe, interpret and explain events while seeking to change them for the better.

Qualitative elements were used to explore and gain a greater understanding of the impact of the life skills program on the participants; the impact of the facilitator; and the impact of external factors on the life skill program (Objectives 1-3). Data were collected by means of observation, written reflections, process notes and journaling, following an AR approach based on similar research by Mcniff, Lomax and Whitehead (1996:77).

Quantitative elements were also used to better describe the effect of the life skills program on participants; the impact of the OT as facilitator; and the impact of external factors on the life skill program (Objectives 1-3). Information was collected by means of a self-administered questionnaire (Delport 2005:168).

Action research consists of cycles as described by Zuber–Skerrit (1996:95). A plan is developed, acted on/implemented, and then followed by observation and reflection. A revised plan is then formed according to information obtained within the previous cycle, which is followed by the implementation thereof and recurrence of the cycle. The AR cycles evolve to support the development of best practice.

The natural progression of data collection and interpretation guided the proceeding cycle design and will be explained in detail in Chapter 3. Multifaceted thematic analysis was used for **qualitative data** as described by Schwalbach (2003:77-78). **Quantitative data** analysis was completed by the Dept. of Biostatistics, UFS, after I had entered data using Microsoft Excel.

1.6 DELIMITATIONS

Leedy and Ormrod (2010:57) state that delimitations are "what the researcher is not going to do" in his/her study. It gives guidelines in order to distinguish between what is relevant and not relevant to the problem.

In this study, the focus was an exploration of the current occupational therapy program and my facilitation of the program, and the following delimitations are stated:

- The study was not a program evaluation.
- The study did not evaluate or measure the effectiveness or outcome of the program.
- The study involves AR, which is a continuous process (a way of life) and therefore did not have a definite outcome or end.

1.7 PURPOSE OF THE STUDY

My intention with this study was to work towards "best practice," thus attaining client-centred practice for life skill groups I presented within the specific context at the PC. The findings were used to make recommendations with regard to the content and presentation of occupational therapy groups at the PC. Recommendations were also made towards addressing external indicators influencing groups negatively at the PC, for improved quality of intervention in order for the service to be enhanced.

Evidence in this study may provide guiding insights and possibly some principles for other occupational therapists presenting life skill groups within sub-acute mental health settings in

South Africa. This study could add to the body of knowledge on psycho-social occupational therapy life skill groups and could contribute towards a greater understanding of client-centred approach with regard to psycho-social life skill group programs for occupational therapy.

My experiences might also encourage other OTs to engage in reflexivity for advancing best practices that are client-centred for their clients in their specific context.

1.8 ETHICAL ASPECTS

Guidelines for ethical conduct were followed during the planning and execution of the study as described by Leedy and Ormrod (2010:101-104) and Strydom (2005b:57).

These guidelines implied several steps to be taken prior to and during the study, which are discussed in detail in Chapter 3 (cf. 3.7).

In short, the following ethical considerations were taken into account:

- Informed consent;
- Protection from harm of participants;
- Privacy and confidentiality of participants; and
- No deception of participants or professional colleagues by the researcher.

Formal consent was obtained from the management of the PC and the owner of the relevant private occupational therapy practice. Informed consent was obtained from all participants. Participation was voluntary and no harm was inferred to any participant. I treated information confidentially, as did all other parties involved in the study. Findings will be made available to the management of the PC and also the owner of the relevant private occupational therapy practice.

The final research proposal was approved by the Ethics Committee of the Faculty of Health Sciences, University of the Free State (ECUFSW136/2013).

1.9 OUTLINE OF CHAPTERS

Chapter 1, the introduction and orientation, provides an overview of the study. The introduction, problem statement, research question and aim of the study are discussed. A summary of the methodology of the study is included, as well as the delimitations and value and importance of the study. Ethical considerations are summarised, and the outline of chapters in this dissertation is included.

Chapter 2, a review of literature, provides the reader with vital information explaining some key concepts, i.e. group therapy, the principles used in psycho-social group therapy, and the psycho-social group therapy program at the PC. Psycho-social occupational therapy groups are also reviewed, including the process of my life skill groups and the frames of reference, models and theories that it is based on, as well as the general profile of the clients attending the groups. Client-centred practice is further discussed as the theoretical framework for the study and the therapeutic use of self is debated. In conclusion the importance of evidence-based practice in order to attain client-centred/best practice is presented.

In Chapter 3, the research methodology is described in detail. Firstly the research approach and study design are portrayed, whereafter the collaborative partners (study population) and sampling are discussed. The chapter continues by describing the AR process, which includes the method and procedures of data collection. The quality criteria for advancing rigour in AR are depicted and continue to the analysis of data. The ethical aspects of the study are explained and, in conclusion, summarised.

Chapter 4 presents findings, commencing with a retrospective reflection in anticipation of the planning of the action research process. This reflection is followed by a description of who the stakeholders were, as well as the reasons for their admittance. Findings on external and internal indicators that had an influence on the stakeholders' experience of the occupational therapy life skill groups are described. The chapter is brought to a close with the presentation of findings regarding the impact of the life skills program on stakeholders (including knowledge gained, enablement, client-centredness and satisfaction).

Chapter 5 builds on Chapter 4, by offering an interpretation and discussion of findings. The chapter is structured around the key concepts of client-centred care, in line with the objectives of the study; and provides triangulation with literature.

Chapter 6 closes the dissertation, offering some final conclusions and recommendations, as well as a discussion of limitations and recommendations for further study.

1.10 SUMMARY

In this chapter, a comprehensive overview of the study was given. It included the introduction and background on the study, followed by the problem statement, research question and aim of the study. The chapter continued with the research methodology, delimitations and ethical aspects, and concluded with the outline of chapters.

In the next chapter, a review of literature provides the reader with contextual information for reading the dissertation.

CHAPTER 2

LITERATURE REVIEW

Chapter 1 offered an outline of the study. The aim of the study is described and an explanation of how this aim was realised is given by means of the methodology of the study.

In this chapter, a review of literature relevant to the study is explained and thereby sets the stage for the remainder of this dissertation. The rationale behind the literature review is to provide a solid theoretical context for the study (Bailey 1997:13). The more sound knowledge a researcher has of studies and viewpoints regarding the theme of their study, the more efficiently it can be attended to (Leedy & Ormrod 2013:51). The chapter also presents the knowledge available on topics relevant to the study.

Figure 2.1 (on the next page) shows the rationale supporting the review of literature.

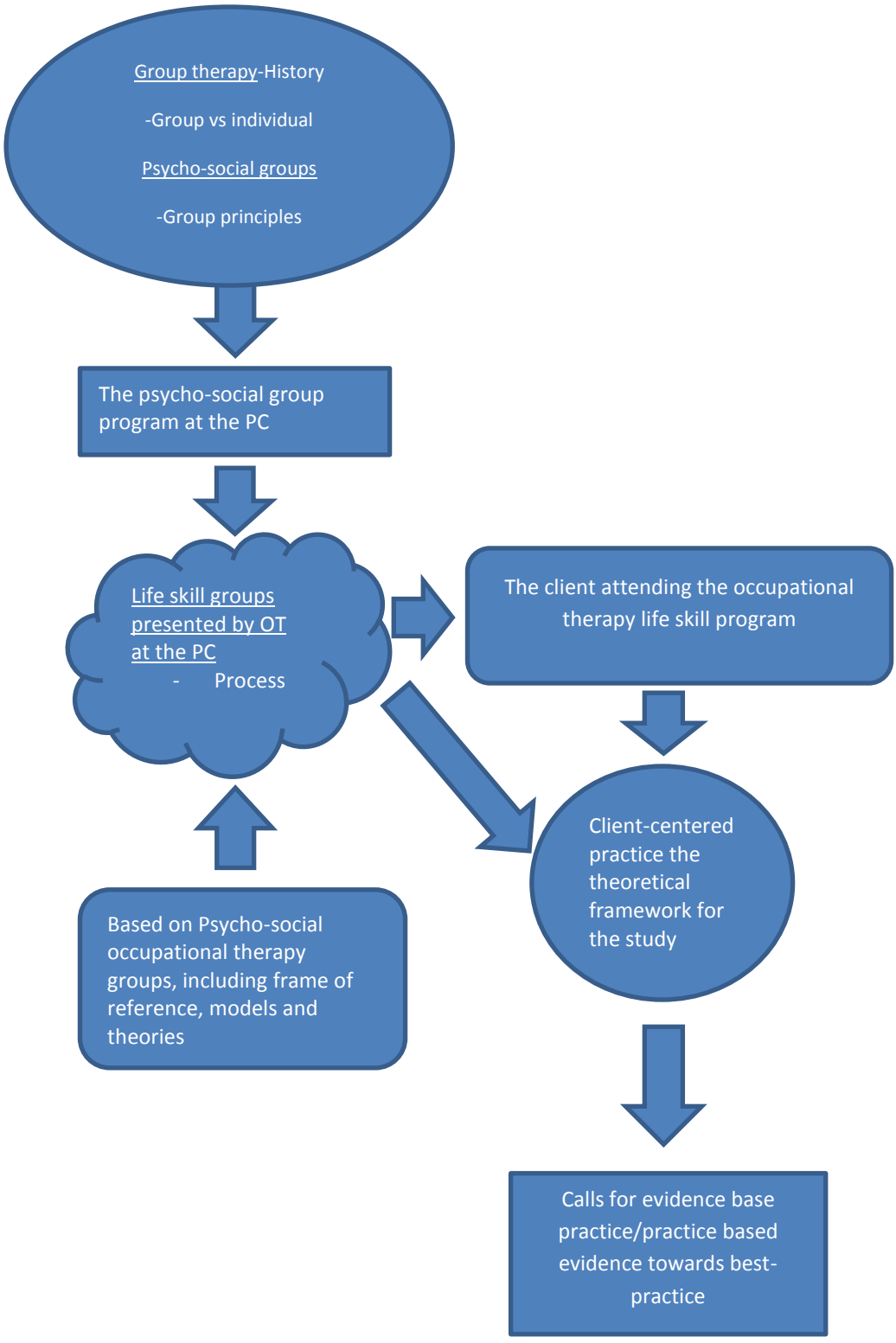


Figure 2.1: The rationale supporting the literature review.

Figure 2.1 starts with an introduction to group therapy and its history. The effectiveness of group therapy versus individual therapy is further debated. It also explains the principles used in psycho-social groups.

After the principles used in psycho-social groups are described, the psycho-social group therapy program at the PC is discussed, explaining the setup and progression of the group program in the two-week admission period.

Psycho-social occupational therapy groups are then reviewed, as the life skill groups presented are seen as psycho-social groups, followed by the position of the occupational therapy groups within the psycho-social group program at the PC. It also explains what these occupational therapy groups entail, including the process of the groups. The frames of reference, models and theories that the occupational therapy life skill groups are based on are then considered.

Furthermore, the profile of the clients attending the group program will be discussed briefly. Thereafter, client-centred practice, which is seen as the theoretical framework for this study, will be reviewed and the therapeutic use of self will be debated.

In conclusion, the importance of evidence-based practice in order to attain best client-centred practice is presented.

As the groups I present – and therefore this study – are embedded within the psycho-social group therapy framework, group therapy, and specifically psycho-social/psychotherapy groups, is now considered.

2.1 GROUP THERAPY

Our experience of groups has an immense influence on our social development (Finlay 1993:3). Finlay (1993:3) explains that we gain knowledge of ourselves and our identity as we interact with other people. In groups we embrace particular roles and react to expectancies from other people. In other words, we need to be able to work together and interact with others in groups in order to survive.

2.1.1 History of group therapy

As mentioned, groups play an important role in our social development. The role of groups in therapy has been studied since the turn of the 20th century, including research by noted figures such as Prat, 1906–1911; Budman, 1992; Budman and Gurman, 1988; and DiMichele, 1992 (Schneider Corey , Corey & Corey 2010:4). According to Schneider Corey, Corey and Corey (2010:15), group psychotherapy started due to a lack of trained staff that could provide individual therapy for the duration of World War II. They also mentioned that at first therapists adopted the traditional role of a therapist as in an individual setting and only later realised that group settings posed distinctive therapeutic potentials. Yalom (1995: xi) also states that long-term groups were initiated in the 1940s and have since changed to accommodate the present-day context of clinical practice. Currently group therapy is very common and used in various settings for various patient groups, and different technical styles are used in the groups (Yalom 1995: xi*)*. Diverse views regarding the use of group therapy exist and we have to acknowledge the differences between individual and group therapy, and what both of these entail.

2.1.2 Individual therapy vs group therapy

Finlay (1993:4) suggests that groups create an ordinary learning situation which has special qualities.

Shapiro, Bernadett-Shapiro and Peltz (1998:4) list the unique advantages of group therapy as the following:

- Group therapy is more cost effective.
- Group therapy offers a form of connectedness to group members; group members can socialise, share experiences with one another, have support, and feel less isolated.
- Group therapy advances reality testing, where group members can learn and practise new behaviour in a real, everyday setting. Group members will thus react differently to a group member than an individual therapist would.
- Group therapy provides vicarious learning, where a group member can learn by observing other group members.
- The group also provides an environment where pathology is minimised in that members give one another assistance with problems. This shows members that their problem is not utterly unmanageable and might help them adopt a more positive outlook on their situation.

- Altruism, which is a therapeutic factor, is usually present.
- Groups also offer experimentation to members: members are granted the opportunity to experiment with behaviour and responses, and they receive feedback from others in a safe atmosphere.
- Groups offer an environment where there is a weakening of transference relationships.

These advantages are reiterated by Cole (2012:70) when she lists the following as potential benefits of groups:

- A milieu of social support is offered.
- Communication and self-expression are developed.
- An environment of non-judgmental acceptance is created.
- Group members can express their own distinctive cultural values.
- Various opportunities of shared learning and use of therapeutic approaches are presented.
- Information is conveyed in a cost-effective manner.
- Group member participation is encouraged.
- Group member group interactive skills are encouraged.
- A good environment is created for problem-solving with other group members.

According to Schneider Corey *et al.* (2010:10), individual therapy does not provide caring, confrontation and the same amount of support that the interaction in group therapy provides. They also state that within the group, clients can practise new social skills, and new insights/knowledge is gained and can be used there.

Wesson (2013:1) explains that in group therapy "the therapeutic alliance is with the group itself" and not only between the client and psychotherapist. She also notes that in group psychotherapy, diverse therapeutic factors are prevalent, which is not prevalent in individual therapy, of which interpersonal feedback from other group members is the most important. In the group, individuals take on different roles and have diverse relationships which help them better understand roles and relationships.

According to Schneider Corey *et al.* (2010:4) group therapy can be as valuable for the treatment of psychological problems as individual therapy. Piper and Ogrodniczuk (2004:642) seems to agree with this opinion as they explain that group therapy can be the treatment of choice for certain types of problems; they highlight efficacy, cost-efficiency and applicability as

the key advantages of group therapy. "Given that group therapy is as efficacious as individual therapy and requires less therapist time, it appears to be the most cost-effective treatment" (Piper & Ogrodniczuk 2004:642).

According to literature, it seems evident that group therapy plays a definite and important role in the treatment of the psychiatric patient.

When a client is admitted to the PC they not only usually attend the psycho-social group program, but also daily see a psychologist for individual psychotherapy as well as their psychiatrist for the management of their medication.

As the OT's method of intervention in the PC comprises mainly group therapy, we have to consider the group principles that it is built on.

2.1.3 Principles of group psychotherapy (therapeutic factors)

The noted psychiatrist, Dr Irvin D Yalom identified in his book, *The Theory and Practice of Group Therapy*, 11 "curative factors" – later called therapeutic factors – that are needed within a group in order to make a group work or to enhance the effectiveness of a group; thus to promote healing in the group (Yalom 1995:2-4). These factors will now be described.

Interpersonal learning – Yalom (1995:17) describes interpersonal learning to be the feedback that a group member gets from other members. They also learn how other people see them and they can become conscious of negative habits or social behaviour that might hurt their relationships. Cole (2012:66) states that aloneness can be terrifying and that "group interventions necessitate interactions among members and afford opportunities to practice forming meaningful connections."

Development of socialising techniques - Yalom (1995:15) describes the "development of socialization techniques" as a therapeutic factor that needs to be prevalent in all therapy groups. He explains it to be social learning, thus the training of fundamental social skills – this can be direct or can happen indirectly.

Catharsis – According to Yalom (1995:80), catharsis is also known as emotional unburdening. As a result of catharsis, cognitive learning and reflection might occur in the group towards positive change.

Group cohesiveness – Group cohesiveness is seen as "the condition of members feeling warmth and comfort in the group, feeling they belong, valuing the group and feeling, in return, that they are valued and unconditionally accepted and supported by others" (Yalom 1995:48).

Self-understanding – Yalom and Leszcz (2005:92) state that self-understanding is also an important therapeutic factor; they explain that self-understanding helps us understand the connection between the present and past within our existence. It will therefor help stakeholders to get to know and understand themselves better. Cole (2012:33) explains that self-understanding is an intellectual component that can be explained as insight into oneself. This self-discovery has two sides to it: it can be positive in the sense that it can help one learn new things about oneself, such as strengths and abilities that can enhance your quality of life; or negative in the sense that one has to accept past negative thoughts or behaviour as part of who you are (Cole 2012:33).

Existential factors – These are factors that are part of being human, such as the unfairness of life, concurrence with pain and death, and other realities of life. This may also introduce the concept of freedom and responsibility to clients and lead them to take responsibility for the choices they make in life (Yalom 1995:88).

Universality – Yalom (1995:6) explains that often patients isolate themselves socially, causing them to feel "a heightened sense of uniqueness" and, because they find it difficult to have interpersonal relationships, they do not have the opportunity to confide in someone or to be accepted and validated by other people. When they hear other group members reveal concerns comparable to their own, they describe feeling more "in touch with the world" and a sense of relief. This mentioned phenomenon is called universality (Yalom 1995:6).

Instillation of hope – The instillation of hope as described by Yalom (1995:4) is needed for the patient to remain in therapy while waiting for other factors to have an influence. It also helps to build faith in the mode of treatment, which makes therapy more effective.

Altruism – According to Yalom (1995:12), altruism is to help others and to thereby feel a sense of wellbeing. It helps members to feel that they are of value to other members, rather than a liability.

Family re-enactment – Yalom (1995:13) explains that this factor is often present at an unconscious level. It is where group members play out the roles in the group that is part of

challenging family backgrounds. The group leader may facilitate this in order for the group members to break from these old roles.

Imparting information – According to Yalom (1995:8), "imparting of information" is also a therapeutic factor. Yalom explains that "imparting of information" comprises didactic educational information or teaching as well as straightforward guidance and proposals from others in the group.

Imitative behaviour – Social learning takes place through viewing others and displaying the effective social behaviour of other group members (Yalom 1995:85).

These factors are valuable as the OT can observe clients in the group and facilitate their development within the means available to the OT. The greater the number of curative factors that are facilitated within any given group, the more therapeutic and healing the group becomes (Yalom 1995:4).

The above-mentioned factors explain which internal factors have an influence on the healing power and effectiveness of the group; however, literature on external factors influencing a psychotherapeutic group and program is limited.

In his doctorate dissertation, Farley (1998:57-59) distinguishes between desirable factors and obstacles towards an effective psychotherapeutic program (cf. Table 2.1). These include internal as well as external factors.

Table 2.1: Desirable factors and obstacles towards an effective psychotherapeutic program (Farley 1998:57-59)

Desirable factors	Obstacles
• No distractions or interruptions • Well-trained staff • All level staff support (admin and clinical) • Homogeneous patients in a group • Patients and groups being on time • Control of milieu • Group based on patient needs and goals • Confidentiality	• Untrained staff • Length of stay (one week is too short) • Distractions or interruptions • Group and patient unpunctuality • Use of medical model • Excessive documentation • Lack of financial support • Heterogeneity of patients • Lack of all level staff support

Table 2.1 shows the ideal environment and circumstances for a psychotherapeutic program. In my opinion, these are not always the factors present when occupational therapy life skill groups are presented at the PC. Some of the obstacles were also listed above in order to show which factors, according to Farley (1998:57-59), strain groups. Some of these obstacles, for example "distractions and interruptions" and "group and patient unpunctuality," may also have an effect on the life skill groups at the PC.

Group therapy, the history thereof as well as the principles used in group psychotherapy have been described. The psycho-social group program will now be discussed in order to explain the context in which group therapy is done at the PC.

2.2 THE PSYCHO-SOCIAL GROUP PROGRAM AT THE PC

After admission to the PC, clients have the opportunity to attend a two-week psycho-social group therapy program. Clients are usually admitted on Sunday evening or Monday morning. They are screened by staff and the group coordinator (an OT) on Monday morning. Clients with psychotic features, symptoms of substance withdrawal and cognitive impairment do not attend groups, and are offered intervention in individual sessions.

The first group session (welcoming) is at 09:30 on Monday morning and is presented by a psychologist who is also the group program's chairperson. Group sessions are presented by psychologists, psychiatrists, a dietician, a physiotherapist and occupational therapists. The program is devised in such a way that specific groups follow one another in order for the sessions to build on one another, and for sessions to complement each other. In the first week of the program the groups focus more on awareness and knowledge, and move towards knowledge, skills and enablement in the second week of the program. The group program runs from 08:30 in the morning to 16:45 in the afternoon, with a 15 minute tea break in the morning and a 90 minute lunch break. The length of each session is 60 minutes (Addendum A). The psycho-social occupational therapy life skill groups form part of the mentioned program and psycho-social occupational therapy groups will therefore now be discussed.

2.3 PSYCHO-SOCIAL OCCUPATIONAL THERAPY GROUPS

2.3.1 Psycho-social occupational group therapy in South-Africa

According to Finlay (1993:9) the aim of psychotherapy groups in occupational therapy is to enhance the client's insight into their individual problems and to assist them in discovering/opening up their feelings. She lists the following groups as typical psycho-therapy groups: play therapy, projective art, verbal psychotherapy and psychodrama.

Published research in the field of psycho-social occupational therapy group programs is limited and studies accessed were done in other countries (UK and USA), with not much information on psycho-social occupational therapy life skill group programs, within a sub-acute setting, in South Africa. There is information available regarding the psychiatric patient and their treatment within the South African context, but not specifically for the type of population within a private clinic and a structured group program. South African literature (Crouch & Alers 2005; Duncan 2005:442; Van Greunen 1997:272-283) on occupational therapy group practice in mental health settings is limited, but suggests similar programs for people diagnosed with mood and anxiety disorders, albeit without specific guidelines as to the facilitation of these groups in the South African setting. The most commonly accessed information on occupational therapy life skill groups in South Africa is the themes/topics presented by OTs at various private psychiatric hospitals, which were accessed by means of websites and information gained from telephonic interviews with these occupational therapists. In some clinics, additional groups are presented according to the length of stay of their clients. (Information was obtained by telephonic interviews with occupational therapists from the listed psychiatric clinics and some websites: http://www.lifehealthcare.co.za/hospitals/Mental_Health_Services.aspx, www.crescentclinic.com and http://www.lifepathgroup.co.za/.)

In order to obtain information on different occupational therapy life skill group programs, five facilities/psychiatric hospitals in four different provinces were contacted as mentioned above.

From the telephonic interviews it was established that the facilities all had the following topics in common with the topics presented by OTs at the PC: stress, self-knowledge, self-image, assertiveness, communication, day planning, and conflict management and boundaries. Topics that differed from the PC's included: emotions, problem-solving, anger management, values, journaling, and drumming. The themes listed are often included as part of psycho-social occupational therapy group programs in literature.

It also has to be taken into account that team members from other professions also present group sessions, and that some topics presented by OTs at one facility may be presented by another team member in another facility. As the above-mentioned topics are based solely on OTs presenting these; it is not clear which topics are presented overall as part of a facility's psycho-social program.

Psycho-social occupational therapy groups in general in South Africa have now been examined. The following description focuses specifically on the psycho-social occupational therapy life skill groups (program) at the PC, and includes the group process, the theoretical frame of reference, and models that provide the foundation for the groups. It also gives a depiction of the population we serve.

2.3.2 The psycho-social occupational group therapy program at the PC

As discussed previously, the occupational therapy group program is set within the PC's psycho-social group program (Addendum A). It consists of two to four groups a day and includes life skill groups, therapeutic creative activity groups, and relaxation therapy. Life skills in this study refer to skills in the program presented/facilitated to clients by an occupational therapist within the set psycho-social group therapy program. These skills include stress management, assertiveness and setting boundaries, addressing anxiety, promoting a healthy self-image, social interaction and communication skills, and conflict management.

For the purposes of this study, only life skill groups mentioned above are explored, as therapeutic creative activity groups and relaxation groups are presented in the afternoon and have a different format from other life skill groups. They are also often presented by other OTs and may include clients from other groups. Therapeutic activity groups and relaxation therapy will therefore, for the purpose of the study, not be included, although it is part of the occupational therapy psycho-social group program.

According to Creek (2008:62), "activity is a flexible and adaptable treatment medium that can be used with all clients in many different contexts to achieve diverse outcomes."

In this study, **activities will refer to the activities used in life skill groups**. These activities include projective techniques, work sheets and warm-up games, and **do not refer to therapeutic creative activities used in groups,** which include techniques such as mosaic work, beading, and material painting, where the focus is on the process of completing the

product. The activities used in the life skill groups might include creative activities, but the approaches (use of it) for each type of group differ, as mentioned by Creek (2008:335). Creek (2008:336) identified different ways in which creative activities can be used therapeutically for a person with mental health problems:

- Increasing motivation.
- Enhancing learning.
- Promoting emotional resilience.
- Coping with chronic stress.
- Increasing satisfaction and self-esteem.
- Enabling self-expression.
- Facilitation projection.
- Providing opportunities for sublimation.

The dynamics and group process of therapeutic activity and relaxation therapy groups are thus different from the life skill groups I presented as a continuum (with the same clients).

According to Roberts (2008:360) skills empower persons to function as individuals and add to their functioning as part of a certain group to which they belong to. She further states that "mental illness can cause disruption and deficit in an individual's skills". The daily competencies of people, which are seen as the norm by society, can become impaired and deteriorated. In the occupational therapy psycho-social groups at the PC, these impaired or deteriorated skills of daily life are addressed and for that reason these groups are defined a "life skill" groups.

"In occupational therapy, a skill is defined as a performance component which evolves with practice. Skills are grouped according to the emphasis of the occupational therapy approach used, for example psychosocial function of cognitive ability. They form the basis of performance, behaviour, cognition and social interaction" (Roberts 2008:360).

As discussed before, the topics addressed in the groups, now defined as "life skill" groups, are as follows: stress management, assertiveness and boundaries, self-knowledge, self-image, anxiety, and conflict handling. The emphasis throughout remains on the communication and interpersonal skills components which are addressed in the life skill groups. An occupational therapist starts with a certain group of clients on the Monday of their arrival at the hospital and remains with this group, accordingly presenting all the life skill group sessions for this group of clients over the two-week admission period.

Table 2.2 contains a summary of the occupational therapy life skill group program at the PC.

Table 2.2: Occupational therapy life skill group program

Week 1

Day	Time	Group
Monday	09:30-10:30	Orientation
	11:45-12:45	Stress 1
	14:15-15:15	Stress 2
Tuesday	09:30-10:30	Self-knowledge
	11:45-12:45	Self-image 1
Wednesday	08:30-09:30	Self-image 2
Thursday	09:30-10:30	Assertiveness 1
	11:45-12:45	Assertiveness 2

Week 2

Day	Time	Group
Monday	09:30-10:30	Stress and my senses
	14:15-15:15	Stress and my personality
Tuesday	08:30-10:30	Self-image
Wednesday	08:30-10:30	Conflict management and boundaries
	15:15-16:15	Anxiety
Thursday	08:30-09:30	Stress management
	09:30-10:30	Plan of action

After the welcoming session, an orientation group session is held by the OT. During this session the matron of the hospital presents the general hospital guidelines to the clients (10 minutes), whereafter the OT orientates clients towards the program, team members involved in the program and general arrangements regarding the group program. Workbooks containing information and worksheets on all the psychosocial groups presented in the two weeks of the program are given out and questions from clients answered. Contracting with clients is done and then the group decides on group rules in order for the clients to feel safe in the group.

After the orientation of clients the OT starts with her first life skill group, which addresses the topic of stress. During the occupational therapy life skill group sessions, structured group procedures are followed in order to help the group flow easily.

2.3.2.1 The occupational therapy life skill group

The group procedure I use for my life skill groups is part of the interactive occupational therapy group model (Fouché 2010). This method helps the group to flow easily as mentioned before, making facilitation a spontaneous process.

Steps (a) to (h) below describe the main components of the group session, and every step is illustrated by a simple example as applied in occupational therapy group sessions at the PC.

(a) **Introduction:** During the first few group sessions, when group members are not familiar with one another's names, introduction is facilitated by simple, fun activities to relieve tension and facilitate cohesion and universality. An example of such an activity is to invite every group member to mention their favourite meal. The therapist always introduces herself first.

(b) **Rules/norms/guidelines:** Contracting to participate in group therapy also includes the setting of rules/norms for participation, set by the group members themselves. Group rules establish structure, which provides security and enhances a sense of cohesion. This setting of norms is only done once, early during the two-week period. It may be repeated again when new group members join the group, or if the therapist or any member feels that many norms are being ignored by members. Examples of group norms include aspects around seating, punctuality, confidentiality and participation.

(c) **Meet group members on their emotional level:** In order to enhance sensitivity towards group members' immediate needs, the therapist may enquire about their emotions/feelings at the time. This provides members with an opportunity to "check in", which again facilitates universality and cohesion. This happens at the start of each group session, and may be done by expressive activities such as identifying a colour with which they associate on the day (based on their emotions), or indicating their level of wellbeing by showing a thumbs up or down.

(d) **Warm-up/ice-breakers:** Ice-breaker activities create energy and flow, and ultimately provide a background for the main theme of the group session. All these factors enhance participation in the group session.

An effective ice-breaker should adhere to most of the five criteria below:

(i) Facilitate cohesion (group members do it together or share something of themselves).
(ii) Facilitate interaction (they should talk to one another).
(iii) Decrease anxiety (there should be movement or eating).
(iv) Increase spontaneity (it should be fun; evoke laughter naturally).
(v) Introduce the theme of the group.

At the PC, an ice breaker activity is utilised during every group session, and is chosen to match the theme of the group session as well as to contain the maximum amount of criteria identified above. An example of an ice-breaker may be "the human knot," during which members take hands and form a knot, which they have to unravel without letting go of one another's hands.

(e) Bridging: A group discussion immediately following the ice-breaker activity has the purpose of providing "bridging" between the ice-breaker activity and the main activity. The OT facilitates the discussion by making use of the following markers:

- **General questions:** The group is asked general questions regarding the warm-up and their experience thereof. The therapist moves from general questions directed at the group to observations made about individual group members, and asks their response to it. The purpose of the general questions is to logically lead the group from introducing the theme in the warm-up to identifying it as something they would like to work on (problem-spotting) to committing to the specific theme and group.
- **Problem-spotting:** During problem-spotting, group members are given the opportunity to identify a problem they have around the theme the OT has selected. Problem-spotting facilitates ownership of each group member. This also ensures that the group members are focused for the group and don't have to wonder what the session is about.
- **Committing to the group/activity:** Once the group members have identified with the problem, it naturally follows that they are now open to committing to the activity and therefore to the rest of the group. The therapist then asks, for example, if the group members want to talk about conflict management.

(f) **Activity:** Once all the group members are committed to the theme of the group session, the group can proceed with the activity. The activity can either be a means to an end or an end in itself. For example, when doing the "rose bush" projection technique, the end is not the drawing of a rosebush, but the insight that members gain. On the other hand, role-play to practise assertiveness techniques can be an end in itself. Seen in another way, the activity is a catalyst to reaching your theme. Activities that create a "here and now" experience, as opposed to facilitating conversation about past events, are the easiest and most effective activities to select for groups. This has the very important implication for activity selection in the sense that whichever theme you want to address, needs to be experienced within the group.

Feedback/Norm-setting: Group members are then given the opportunity to give feedback on the activity or explain aspects of the activity or their experience thereof. The therapist also participates in the group. She acts as a role-model through participation in the group and this often determines the level of sharing.

(g) **Post-activity discussion:** By this stage the activity has been completed and, if the activity requires it, all group members have been given the opportunity to share their view of the activity that just took place. Now is the time to facilitate the post-activity discussion, incorporating feedback from group members and facilitating interaction about concepts. The therapist can use some guideline questions and information can also be given through to ensure that the selected theme will be achieved. In order to work towards client-centredness, the OT attempts to facilitate the group members to focus on the group at first, but then to move their focus inward towards themselves in order to achieve insight and self-knowledge. Although therapy is done in the group, the OT still attempts to focus on the individual within the group.

(h) **Closure:** Once the discussion has been completed, the group session can conclude. The closure offers an opportunity for the group session to have a definite end. It makes use of quiet reflection, introspection and summarising. The therapist provides a chance for anchoring any core ideas which the group members would like to take forward with them and generalise in "outside" situations.

The above-mentioned steps are not all always present in one group session, but generally most of these are (Sometimes only done in short).

Although the procedure used for occupational therapy life skill groups is based on the interactive occupational therapy group model (Fouché 2010), other frames of reference, theories and models also form part of the foundation of these groups.

2.3.2.2 Frames of reference models and theories

There are many frames of reference, models and theory used in occupational therapy as, for example, portrayed by Cole and Tufano (2008:282).

The theories presented in this chapter are used as they reinforce and support the group process and experiential learning, which forms vital components of the life skill groups. The theories supporting these include 'group psychotherapy theory', 'adult learning theory' and the 'cognitive behavioural frame of reference'. The 'interactive occupational therapy group model' guide progression of the occupational therapy life skill group and the 'psycho-dynamic frame of reference' forms the foundation for therapy for the typical client (with mood or anxiety disorders) attending the occupational therapy life skill groups.

The following table lists these different frames of reference, models and theory that form the basis for the occupational therapy life skill group sessions I present. It also shows the focus of the particular frame of reference, model or theory and explains how it impacts on and guides the group sessions I present (Cole & Tufano 2008:282, Fouche 2010, Hoffman 2009:164).

Table 2.3: Frames of reference, models and theory for OT life skill groups I present (Cole & Tufano 2008:282, Fouche 2010, Hoffman 2009:164)

Frame of reference/model or theory	Focus	The application -How is it used in my life skill groups?
Cognitive behavioural frame of reference **Theorists/year(s)** Bandura, Beck, Ellis, 1970s (Cole & Tufano 2008: 282)	Changing thoughts, beliefs, emotions, and behaviour. (Cole & Tufano 2008: 282)	The aim is for clients to recognise negative thinking which may lead to destructive behaviour. The aim here is also to change clients' negative thoughts, beliefs, emotions and behaviour. (Cole & Tufano 2008: 282, Fouché 2010).)
Psycho-dynamic frame of reference **Theorists/year(s)** Freud, 1900+, Fidler 1950s, Mosey, Llorens, 1970s (Cole & Tufano 2008: 282)	Mental illness, emotional response to illness. (Cole & Tufano 2008: 282)	The aim of the use of the psycho-dynamic frame of reference in my groups is to put focus on the importance of interpersonal relationships in therapy and to explore the transferences and interactions which occur within therapy to help clients understand themselves better. I use group situations to explore wider relationship dynamics and recognise the potential power of the unconscious and people's use of defence mechanisms when they are in pain or conflict. I use the projective potential of activities to encourage the expression and exploration of feelings (I refer here to activities used in the life skill groups, not creative therapeutic activities). (Cole & Tufano 2008: 28, Fouché 2010)
Adult learning (Andragogy) theory **Theorists/year(s)** Knowles 1970s (Hoffman 2009:164).	Adult learning is a theory of how adults learn and it accentuates the value of learning. It uses approaches to learning that are problem-based and collaborative rather that didactic and also highlights equality between the teacher and learner. The six principles of adult learning identified by Knowles are: ▪ Adults need to know why they need to learn something before beginning to learn it. ▪ Adults need to be actively involved in learning. ▪ Adults have problem-centred orientation to learning. ▪ Adults enter the learning process with prior experience. ▪ Adults' readiness to learn will impact on the outcomes of their learning. ▪ Adults are most motivated to learn when they see the content as relevant. (Hoffman 2009:164).	I use these principles in the group as it leads clients to better learning, transference and the acquirement of skill (Fouché 2010, Hoffman 2009:164).

Interactive occupational therapy group model **Theorists/year(s)** Vorster and De Beer 1980s (As already discussed) (Fouché 2010)	**Interactive occupational therapy group core concepts:** ▪ Groups as part of a micro-organism. ▪ Groups as a mini-society. ▪ Interactive groups. ▪ Direct communication. ▪ Here and now. ▪ Leading from behind. **Interactive occupational therapy group procedure** 1. Introductions. 2. Rules/norms/guidelines. 3. Meeting group members on their emotional level. 4. Warm-up/ice-breaker. 5. Bridging: • General questions • Problem-spotting • Contract/commitment 6. Activity 7. Feedback norm-setting 8. Post-activity discussion 9. Closure (Fouché 2010)	I use the principles of the interactive occupational therapy group model in my groups as it makes groups flow easier, making facilitation a natural process. Experiential learning is promoted (Fouché 2010).

In order to gain perspective on the occupational therapy life skill groups as previously discussed, a better understanding of who the clients were that attended the life skill groups I facilitated was necessary. In the next paragraph a brief description of the client with mood or anxiety disorder (viewed as the most common diagnoses for clients attending my occupational therapy life skill groups) and the influence of mental illness on their participation in occupations.

2.3.2.3 The mental health client

"Occupation" refers to purposeful and meaningful participation in activities ranging from self-care, productivity and leisure (Wicks & Whiteford 2008:199). Balanced participation in occupations is required for overall well-being, and specifically sound mental health (Chapparo & Ranka 2005:57, Creek 2008:76, Blair, Hume & Creek 2008:26, Molineux 2004:2). A person diagnosed with mood or anxiety disorder often shows symptoms within their emotional, cognitive and motivational functioning. This negatively influences their balanced, effective participation in meaningful daily activities as listed above – thus their occupations.

The focus of occupational therapy treatment/intervention is to help a person to live their life as independent and effective as possible; to have balanced participation in their occupations in order to achieve optimal quality of life. The preferred modality of treatment is through participation in meaningful activities (Blair *et al.* 2008: 26, Chapparo & Ranka 2005:57, Creek 2008:76; Molineux 2004:2).

Creek (2008:62) states that the therapeutic process is greatly influenced by the relationship between the client (as reviewed above) and their therapist. Client-centred practice is thus necessary for a successful therapeutic relationship/process and will be discussed next.

2.4 CLIENT-CENTRED PRACTICE

2.4.1 What is client-centred practice?

Literature shows that some studies have been done to determine if client-centredness is part of our occupational therapy practice, and also investigated the perspectives of clients and OTs on these topics (Law *et al.* 1995:250-257; Maitra & Erway 2006:298-310; Smyth & Sumsion 2000:15-21).

According to Maitra and Erway (2006:308), there are different perceptions between OTs and their clients regarding the use of client-centredness. They call for the development of a systematic strategy to be used by OTs to prompt clients to become occupied with the role they want to play in the therapeutic process. Smyth and Sumsion (2000:15-21) state that the biggest barrier preventing client-centred care is that the client and therapist have different goals. They also illuminate the occurrence that therapist's attitudes, beliefs and values made client-centred care difficult.

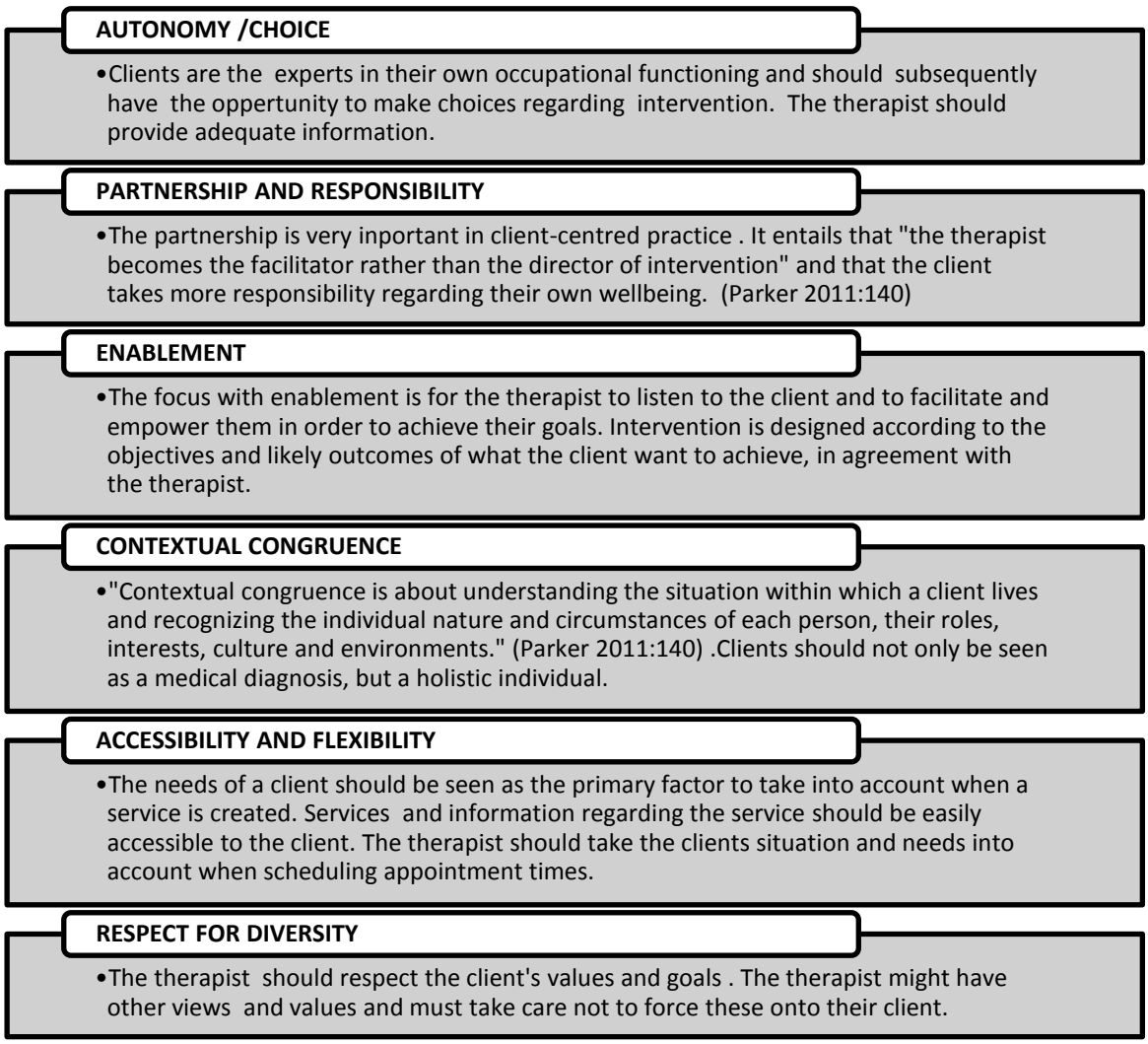
Most of these studies were done addressing client-centredness within individual occupational therapy intervention. There is, however, little literature that directly addresses the question of client-centredness in groups and specifically psycho-social occupational therapy groups.

As OTs, we regard client-centred care as a key element of our practice, with the client being at the centre of intervention (Law *et al.* 1995; Parker 2011:139; Sumsion 2006:1). Townsend *et al.* (2002:80) also emphasize this and mentions that client-centred care should demand collaborative and partnership approaches; the client should be included in decision-making and the clients' experience and knowledge should be recognised. In a client-centred model, the OT and client collaboratively take part in the therapeutic process (Boyt Schell, Scaffa, Gillen & Cohn 2014:54).

What does a client-centred frame of reference mean and what does it entail in practice? Parker (2011:150) declares that by understanding the key concepts of client-centred practice, we

should be able to apply the client-centred frame of reference with clients within our own context. These key concepts are set out in figure 2.2.

Figure 2.2: Key Concepts in client-centred practice (Adapted from Law *et al.* 1995; Parker 2011:140-141)



In April 2006, the Substance Abuse and Mental Health Service Administrators (SAMHSA) in the United States released a definition for recovery in mental health: "Mental health recovery is a journey of healing and transformation enabling a person with a mental health problem to live a meaningful life in a community of his or her choice while striving to achieve his or her full potential" (SAMHSA 2006:5). They also indicated that there are 10 fundamental components to recovery: Self-direction; individualised and person-centred; empowerment; holistic; nonlinear; strengths-based; peer support; respect; responsibility; and hope (SAMHSA 2006: 5-7). These components correspond well with the key concepts of client-centred practice and echo the suggestion that clients need to be involved in their own recovery.

Our responsibility to utilise client-centred practice is reiterated in the South African Health Professions Act (56/1974), which states the main responsibilities of health practitioners as it confirms many client-centred practice principles. These responsibilities are listed in the South African Health Professions Act 56/1974 and state that a practitioner shall at all time:

(a) Act in the best interests of their patients;
(b) Respect patient confidentiality, privacy, choices and dignity;
(c) Maintain the highest standards of personal conduct and integrity;
(d) Provide adequate information about the patient's diagnosis, treatment options and alternatives, costs associated with each such alternative and any other pertinent information to enable the patient to exercise a choice in terms of treatment and informed decision-making pertaining to their health and that of others;
(e) Keep their professional knowledge and skills up to date;
(f) Maintain proper and effective communication with their patients and other professionals;
(g) Except in an emergency, obtain informed consent from a patient or, in the event that the patient is unable to provide consent for treatment themselves, from their next of kin; and
(h) Keep accurate patient records.

Parker (2011:139), however, states that in everyday life with pressures in the workplace, there is little guarantee that client-centred care actually occurs as described in theory within the client-centred frame of reference. This is also echoed by Rochon, Wilkins, Law and Pollock (2001:71) when they state that OTs find it difficult to apply client-centred practice.

With the client-centred descriptions as set out in figure 2.2 and barriers to client-centredness highlighted, we must recognise that the current environment and context at the PC might compromise the client-centredness of intervention.

From my experience, factors that might influence client-centredness include:

- The clients' mental health standing at the time of commencement of the group sessions (as many clients are still very anxious, upset or depressed at that time);
- The clients' capacity for decision-making at the time of admittance (influencing autonomy);
- The clients' motivation and commitment towards services rendered (influencing partnership and responsibility);

- Limited time for individual interviews before the client joins the group (influencing enablement and contextual congruence);
- Clients randomly becoming part of a group and not having the opportunity to select a group (influencing autonomy);
- A set life skill program with five to 12 clients in a group (influencing autonomy); and
- Uniqueness of an individual (influencing contextual congruence).

Client-centred practice is viewed as the occupational therapy theoretical framework in support of the ethos of this study.

As discussed above, we have to acknowledge that the current environment and context at the PC might compromise the client-centredness of intervention, and also recognise that my "therapeutic use of self" may also have an influence.

2.4.2 Therapeutic use of self

The American Occupational Therapy Association (AOTA) defines therapeutic use of self as a "practitioner's planned use of his or her personality, perceptions and judgements as part of the therapeutic process" (Punwar 2000: 285). Taylor and Van Puymbroeck (2013:36), define the therapeutic use of self to be "an integral part of the occupational therapy process which allows occupational therapy practitioners to develop and manage their therapeutic relationships with clients by using narrative and clinical reasoning; empathy; and a client-centred, collaborative approach to service delivery".

According to Yalom (1995:48) research evidence shows overwhelming support that in order to have successful therapy there must be a good therapeutic relationship between the therapist and the patient which should portray acceptance, empathic understanding, trust and warmth. The therapist's "therapeutic use of self" should thus show the above-mentioned characteristics.

Martin and Wheatley (2008:242) explain that "the therapeutic use of self" can be seen as the deliberate use of self by the therapist to prompt/enable a positive therapeutic outcome by reacting or responding to a client in their milieu. The therapist therefore understands/acknowledges that their presentation of themselves can influence the value of the therapeutic relationship. It is thus evident that my "therapeutic use of self" will have an impact on the value and outcome of my life skill groups.

In order to thus effectively fulfil the role of group leader/facilitator and to relate effectively with group members, a person has to have certain skills and qualities/traits (Schneider Corey *et al.* 2010:19-33), which are listed in the following table:

Table 2.4: Skills and traits needed in order to be a group facilitator (Schneider Corey *et al.* 2010:30-38)

Skill/Trait	Explanation
Own personal problems, values and biases	To make sure these do not affect the facilitation of groups or interfere when you are engaging with clients.
Respect	To respect differences with your clients, for example regarding their religion, spiritual beliefs and morals.
Recognise your own limitations	Ask for feedback from patients and get help from colleagues or additional sources when needed.
High level of self-awareness	Participate in continuing self-reflection. Often audit your own life.
Courage and willingness	• Admit mistakes and deficiencies. • Also expose yourself in the group, as group members also have to expose themselves and take risks. • Confront group members, but stay connected to them. • Work through conflict. • Show that you are touched by group members. • Show respect and that your care, but be direct and honest.
Model	Be willing to model behaviour, for example acceptance for others and openness.
Be present	Be in the moment, pay attention.
Genuineness and caring	A genuine, honest attentiveness in the wellbeing of group members.
Believe in the group process	Have confidence that the group process has value and leads to constructive outcomes.
Openness/self-disclosure	Show some of who you are to group members.
Cope with criticism	Do not react offensively when challenged with criticism. Model non-aggressive responses and express your feelings and thoughts in a constructive way.
Personal power	Do not abuse your "power" as group facilitator to manipulate or control group members to work towards the outcome you want.
Trust your competence	You need self-confidence in order to motivate and create a feeling of empowerment for the group members.
Have realistic expectations of the group	Unrealistic goals or expectations might cause you to lose your enthusiasm or emotional energy (feeling drained) when the group does not "achieve" as you would have liked them to.
Commit to self-care	In order to sustain your emotional energy levels, you have to look after yourself and get the needed support and counselling.

The information above is reflected in Mosey's 11 elements influencing the ability of the therapist to relate successfully with clients (Creek 2008:62), namely: a perception of individuality; respect for a client's rights and dignity; empathy; compassion or sympathy; humility; unconditional positive regard; honesty; a relaxed manner; flexibility; self-awareness; and humour.

If the therapist relates successfully with clients it can be beneficial towards "partnership and responsibility," which is one of the key elements of client-centred practice as described by

Parker (2011:140–141). He mentions that "partnership and responsibility" is very important in client-centred practice. It entails that "the therapist becomes the facilitator rather than the director of intervention" and that the client takes more responsibility regarding their own wellbeing.

In view of the previous information it seems likely that my "therapeutic use of self" will have an impact on client-centredness and the value and outcome of my occupational therapy life skill groups. Therefore my therapeutic use of self was also taken into account as an internal factor influencing my life skill groups.

When taking client-centred practice into account, the question has to be asked as to whether generalised life skill groups supports client-centred practice for a specific individual at a certain time within the context of life skill groups at the PC. Evidence for supporting best practice should be considered when addressing this problem.

2.5 EVIDENCE-BASED PRACTICE

Cara and MacRae (2005:690) state that worldwide the occupational therapy profession is calling for and working towards the establishment of evidence-based practice. According to Boyt Schell *et al.* (2014:55) evidence-based practise entails "being able to integrate research evidence into the professional reasoning process to explain the rationale behind interventions and predict probable outcomes." Major occupational therapy journals show an increase in articles on how to locate and apply evidence in practice (Cara & MacRae 2005:690). The importance of evidence-based practice is thus echoed by many authors of occupational therapy books and journal articles, such as Bennett and Bennett (2000:171); Law and MacDermaid (2008:3) and Rappolt (2003:589).

"Evidence-based practice includes experiential, qualitative and quantitative evidence. The occupational therapist provides knowledge of client, environment, and occupational factors relevant to enabling occupation. Ideally, this evidence is derived from a critical review of the research literature, expert consensus and professional experience" (CAOT, ACOTUP, ACOTRO, and PAC, 1999:267) in Townsend and Polatajko (2007:368).

At a POTS (Psychiatric Occupational Therapists Group) Symposium in May 2011, South African occupational therapists were urged by speakers to do research, and to have evidence on what they do and the outcomes thereof, rather than having only good intentions. As occupational

therapists we have to become actively engaged with attaining "best practice" (Blair & Robertson; 2005:269), not only for our clients, but also for our profession. We need to have evidence to show what we do and the outcome thereof, in order for example to inform medical aids of the services we render and the importance thereof. The only way we can attain best practice is thus by keeping up to date with new theory and practice, exploring what we do and adapting our service to be the best it can be.

Ilott (2008:175) indicates that evidence-based practice is of utmost importance as it guides us into a more effective and assured future. In order for patients to receive the best possible service, it is of great importance to use evidence to find solutions (Beighton 2008:154-155).

Boyt Schell *et al.* (2014:55) ask that practitioners look at the effectiveness of intervention and evaluation practices by being willing to asses it. They also call for openness towards change in their way of practicing when more effective approaches are proposed by evidence.

In this study I hope to combine the concept of "evidence-based practice" with a "practice-based evidence" approach. The reason for this is that although previously published evidence of best practice for the client group I serve would be reviewed, I am aware that there is very little published that is specifically associated with occupational therapy research for the South African context that I work in. In this study I will endeavour to verify principles for practice/generate practice-based evidence on how to continually address client-centredness in my life skill groups as to ensure best practice for the clients I serve. Action research was thus used in the clinical context to simultaneously gain insight into my current occupational therapy life skill groups and generated evidence for practice.

2.6 CONCLUSION

The review of literature set off with a discussion of group therapy and its history. A deliberation followed regarding individual and group therapy and it is evident that group therapy is acknowledged as a therapeutic and effective practice in psycho-therapy and has many benefits. The therapeutic factors (principles) as portrayed by Yalom (1995:1) were described as factors having an influence on the effectiveness of the group. Thereafter the psycho-social group therapy program at the PC was discussed, explaining the setup and progression of the group program in the two-week admission period.

Psycho-social occupational therapy groups were then reviewed, highlighting the fact that little evidence on these groups in a South African context and within a similar setting is available. The position of the occupational therapy groups within the psycho-social group program at the PC was described and the procedure based on the interactive occupational therapy group model depicted. The other frames of reference, models and theories that the occupational therapy life skill groups are influenced by were also considered.

Furthermore the profile of the clients attending the group program was briefly discussed. Thereafter client-centred practice, which is seen as the theoretical framework for this study, was reviewed and the therapeutic use of self was debated. In conclusion, the importance of evidence-based practice in order to attain best client-centred practice and to answer the research question was portrayed.

The following chapter, Chapter 3, presents the research methodology utilised in exploring how I can gain insight into my current facilitation of a pre-determined/structured two-week life skill program as to continually address best client-centred practice for the clients I serve.

CHAPTER 3
RESEARCH METHODOLOGY

3.1 INTRODUCTION

The research problem stated in the first chapter identified the need to explore the life skill groups I facilitated in order to gain insight into the immediate effect of the life skills program on stakeholders as individuals and what possible internal and external factors could also influence aspects of these groups. In this chapter, the framework for answering the research question is described. The rationale for selecting action research (AR) with a multiple-method approach is explained. This is followed by a discussion of the study population, including sampling and sample size. An explanation of the AR process and measurement used for the study, comprising the method and procedures of data collection and analysis, will then follow. In conclusion, rigour in AR and consideration for possible methodological and measurement errors, together with ethical considerations in this study, are provided.

3.2 RESEARCH APPROACH AND STUDY DESIGN

Action research is an evolving area within especially health sciences, but the seminal work by Zuber-Skerritt (2001:3-7) is the foundation for this study. This author explains that AR is situated within the social sciences and not the natural sciences; therefore, this paradigm includes human beings, groups of people, organisations or societies with complex (unpredictable) characteristics, ideas, strategies and behaviours.

The AR process followed within this study included components of both phenomenology and ethnography. Zuber-Skerritt (2001:7) explains that with a phenomenological approach information is socially pieced together from inside a specific situation/group setting. The role of the researcher is to, as truthfully as possible, depict the circumstances or case. The goal is to not construct universal principles for several contexts, but to gain knowledge and understanding, or to change a certain social position in order for it to be beneficial to persons influenced by the outcome and solutions. The method pursued is Technical AR that involve ethnographic features (Herr & Anderson 2005:24-25) as the researcher scrutinise her own practice to ensure that she evolve her skills to be more client-centred when presenting life skills within a set program with pre-determined themes. Stakeholders only participate in the AR

process while in-patients at the clinic (i.e. in one of the AR cycles) and valuable contributors as a participatory AR approach was not viable in this setting. Zuber-Skerrit (1995:14) defines AR as a critical and self-critical collaborative enquiry by practitioners who are accountable and transparent regarding the work they do. They assess their own practice and engage in problem-solving with others as a course of their ongoing professional development.

Zuber-Skerrit (2001:6) distinguishes between a technical rationality on the one side and reflective rationality on the other, as presented in Table 3.1. The table shows the different rationalities in order to clarify which rationality was suitable for this study.

Table 3.1: Basic assumptions of Opposing Views of Problem solving (Zuber-Skerrit 2001:6)

	Technical rationality	**Reflective rationality**
Problem solution	These are general solutions to practical problems.	Complex practical problems demand specific solutions.
Method	These solutions can be developed outside practical situations (in laboratories and research centres).	These solutions can be developed only in the context in which the problem arises and in which the practitioner is a crucial and determining element.
Application	The solutions can be translated into practitioners' actions by means of training, publications, etc.	The solutions cannot be successfully applied to other contexts, but they can be made accessible to other practitioners as hypotheses to be tested.
Credibility	Hierarchy in the institutional power structure – the closer a person is to policy-making and theory development, the more credible and powerful they are. Separation of theory and practice.	New types of communication – networking, symmetry of communication and collaboration. Integration of research and development, theory and practice.

It is evident from Table 3.1 that reflective rationality supported this study as this study poses a definite question that needs a specific answer within a specific context. This study within the AR framework is thus constructed in the **non-positivist paradigm of reflective rationality.**

Embedded in the AR process are multiple data collection methods. Bowling (1997:367) states that AR often uses multiple research methods. These methods are mostly qualitative, but quantitative questionnaires could also be used. In this study qualitative methods together with quantitative checklists were used. According to Creswell (1994:175), traditionally the most common reason for using different qualitative and quantitative methods together in a study is for triangulation, thus seeking overlapping of results. Additionally, quantitative and qualitative research methods could complement each other by offering various sides of a process. In this study, a multiple method approach also supported data and method triangulation and contributed towards the trustworthiness of the study.

Action research (AR) with a multiple-method approach (mostly qualitative elements in daily reflection activities for stakeholders and the group presenter as well as some quantitative elements such as checklists) was thus conducted as the focus was on the **cyclical** nature of continuously evaluating and planning input (Ebersohn, Eloff & Ferreira 2007:125-130).

One characteristic of AR is to ensure involvement of the people for whom the findings could effect, as the underlying aim of of the investigation is improvement of an intervention (Henning, Van Rensburg & Smit, 2004:47). Bhana (2006:432) highlights that action research supports a dynamic partnership with the people that will be influenced by the information gained. The specific intention for information gained is to better the circumstances of these mentioned people on a social, educational and physical level. Action research, even when not specifically participatory on all levels, attempts to gain understanding in association with others, rather than relying on the researcher as an outsider's perspective alone (Bhana 2006:432). Therefore in this study, stakeholders are valuable contributors to the AR process even though a technical action research approach is followed.
The nature of the AR is best decribed by Bassey (1995:6) who specified the evolving process of describing, interpreting and explaining events while continuously seeking to change them for the better. The "change for the better" as mentioned previously is a key concept inherent to AR.

As the aim of the study was to explore the current life skills program in order to enhance client-centred practice within the specific context, it was evident taking the above-mentioned definitions and explanations into account, that AR provided the best foundation for this research study. The collaborative component especially is a justifiable methodology to acquire information which goes beyond the boundaries of traditional research and supports a client-centred comprehension of knowledge (Letts 2003:77).

The nature of this AR process was more focused on my journey to attain growth and improvement of my practice skills, rather than the influence of the study on the study participants. In this study AR, including the involvement of stakeholders (insiders), was used as an instrument of exploration towards attainment of best practice.

Action research consists of cycles. Zuber–Skerrit (1996:95) explains AR by means of a diagram (Figure 3.1) as shown below. A plan is developed, acted on/implemented, and then followed by observation and reflection. A revised plan is then formed according to information obtained within the previous cycle, which is followed by the implementation thereof and recurrence of the cycle. The AR cycles evolves towards best practice.

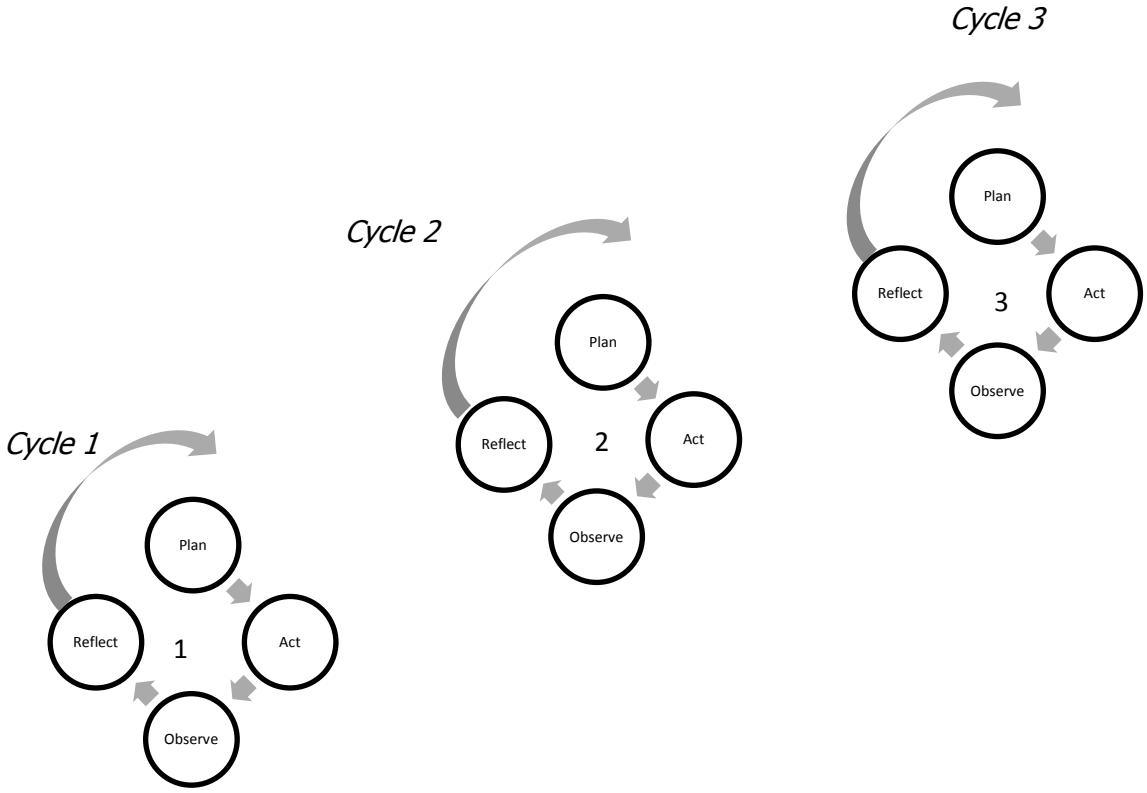


Figure 3.1: The spiral of action research cycles (Zuber-Skerrit 1996:95).

For the purposes of this study, the "Plan" phase of the study is referred to as stage 1, "Act/Implement" as stage 2, "Observe" as stage 3, and "Reflect" as stage 4, as summarised in Table 3.2. The table further lists the "action" prevalent in that specific stage and also what that action entails.

Table 3.2: Phases/stages of the AR cycle (Zuber-Skerrit 2005:3)

Stage 1	Plan	To cultivate a plan analytically advised to better the current situation.
Stage 2	Act/Implement	To act; to execute the plan.
Stage 3	Observe	To observe/examine the outcomes of critically informed action within the specific context.
Stage 4	Reflect	To reflect on the outcome as a foundation to advance planning and promote future critically informed action. This is done through a progression of cycles.

The table shows the stages towards improvement of a specific situation, thus the practical impact of an AR cycle on service delivery. If there is a problem, a plan is cultivated; the plan is implemented, observed and reflected upon, and then changed towards the next AR cycle. The cycles continue until there is a solution (improvement in the service delivery).

During a conversation Du Toit (2011) described AR as "a way of life," an endeavour to strive for "best" practice. It is a continual process as each client/group has a new and unique set of circumstances and needs. It would therefore be more accurate to say that along the AR road the program is advanced and is the best for that specific moment within the AR process. For the aim of this study, three AR cycles were completed to ensure that data provided sufficient depth to report on, and that saturation were reached in order to support the credibility of the study.

In this study the plan (stage 1) of the first cycle included retrospective reflection, planning structured reflections, and then implementing the current predetermined occupational therapy program. This stage thus incorporated a preparative planning phase, similar to a pilot study. It continued onto the act/implementation (stage 2), observation (stage 3) and reflection (stage 4), stages of the AR process (cf. Table 3.6, Figure 3.2). The second and third AR cycles in the study involved all four stages of the AR cycle.

Qualitative elements based on reflexivity were used to explore and gain a greater understanding of the effect of the life skill program on the participants, the effectof the OT as facilitator, and impact of external factors on the life skill program (Objectives 1-3). Johns (2004: 4) defines reflexivity to be "looking back and reviewing self-development over time" or "the way insights have emerged to influence future experience." Data were collected by means of observation, written reflections, process notes, journaling and a questionnaire following an AR approach as discussed by McNiff *et al.* (1996:77). An example of each of the data collection methods follows in 3.4.1.

Quantitative elements were also used to better describe the effect of the life skill program on participants, the effect of the OT as facilitator, and impact of external factors on the life skill program (Objectives 1-3). This information was collected by means of a self-administered questionnaire and daily written reflections by stakeholders, including checklists. The aim of the questionnaire and reflections was to obtain opinions on a certain situation/topic from the stakeholders who were directly involved and had knowledge of their experience of the groups.

Some data collecting documents contained qualitative as well as quantitative elements (cf. 3.4.1., Table 3.4).

3.3 COLLABORATIVE PARTNERS (STUDY POPULATION)

Strydom (2005a:194) describes the study population to be the entire group of persons, events, organisation units, case records or other sampling units by which the research problem is affected. The population is thus the larger group from which the sample of participants is selected (Carpenter & Suto 2008:77).

As this study used AR as method of data collection, the role of the study population within AR has to be clarified. As previously discussed, the study population within this study consisted of stakeholders. Dick (2002:3) explains that stakeholders are the persons influenced directly by current or future occurrences – thus any person that is touched by change or has an influence towards change. As clients attending the OT's life skill groups are affected by what is happening within the AR process, and as it may also affect what will happen in future groups, it was essential to involve clients (i.e. the receivers of the service) in the study. My perspective as outsider differs from the clients' reality as insiders. In order for me to understand the insiders' culture, viewpoint, insights and perspectives on the situation, the active involvement of stakeholders (insiders) was key to the process.

In this study the population (stakeholders) consisted of clients who attended the Afrikaans group program at the psychiatric clinic, after being admitted to the clinic by a psychiatrist. The focus was on the Afrikaans group, as I presented mainly these group sessions. This population included male and female clients older than 18 years, with various mental health diagnoses, of which mood (depressive) and anxiety disorders were most common. The number of potential stakeholders in a group in one cycle would generally range between five to 12 people (cf. 3.3.2.).

3.3.1 Sampling

According to Leedy and Ormrod (2013:152), Nieuwenhuis (2007:79) and Polit and Beck (2006:260), sampling is the process where a portion of the population is selected in order to represent the entire population. As action research is most commonly seen to use a qualitative approach, **convenience sampling** within the **qualitative non-probability framework** was used for this study (Leedy & Ormrod 2013:142, Nieuwenhuis 2007:79).

All clients (potential stakeholders) who matched the inclusion criteria (cf. 3.3.2) were included in the study. Potential stakeholders who matched the criteria on the first/second day of the occupational therapy program were asked to participate in the study. Participation was voluntary. A comprehensive approach was followed by which all potential stakeholders were given an equal opportunity to participate in the study and by which all potential stakeholders was encouraged to be involved in the study. When potential stakeholders agreed to participate, they become stakeholders and therefore collaborators in the AR process.

3.3.2 Sample size (Unit of analysis)

As action research commonly uses a qualitative approach, it more often focuses on the process and not the size of the sample (Strydom & Delport 2005:328). According to Strydom and Delport (2005:328), when using a qualitative approach there are no "set of laws" regarding the sample size – they describe sampling in qualitative research as "being relatively limited, based on saturation, not representative, the size not statistically determined, and involving low cost and less time."

Polit and Beck (2006:273) mention that a unit of ten participants or fewer is usually sufficient for qualitative studies, and propose the principle of saturation. The sample size for the study could not be confirmed before the onset of the study as convenience sampling was used, and the sample size thus depended on the number of clients matching the inclusion criteria of the study admitted to the PC at the time of the research. The unit of analysis depends more on the number of AR cycles and saturation, as discussed previously, rather than the number of participants.

The sample size of the study comprised a total of 39 stakeholders, which included 10 stakeholders in Cycle 1, 20 stakeholders in Cycle 2 and nine stakeholders in Cycle 3.

Saturation in this study meant that data obtained/insight gained (by me as the researcher) no longer justifies further addressing internal and external aspects in the quest towards best client-centred practice.

I included three AR cycles in the study. This means that three different groups of stakeholders who attended my two-week occupational therapy life skill program within the execution period of four months were included in the study. After three cycles saturation was reached, indicating that I was convinced that I had attained insight as to aspects that could promote best client-centred practice within the specific context. My conviction was based on the fact that no further (new) recommendations were made by stakeholders, some information was repeatedly noted by stakeholders, and no stakeholder recommendations referred back to how life skills were facilitated in previous cycles.

The following inclusion and exclusion criteria were used for this study:

Inclusion criteria

- Potential stakeholders attending the Afrikaans option for the occupational therapy life skill program presented by me after admittance to the PC.
- Potential stakeholders who were 18 years or older (not school-going).
- Potential stakeholders who were willing to participate voluntarily.

The above-mentioned criteria matched the description of the Afrikaans adult client who attended the psycho-social group therapy program.

Exclusion criteria

- Clients who were psychotic, who had symptoms of substance withdrawal, or with cognitive impairment.
- Clients who could not read and write.

The above-mentioned clients were excluded from the study as their participation might have influenced the credibility and ethical aspects of the study.

3.4 THE ACTION RESEARCH PROCESS (MEASUREMENT)

I collected data in different ways according to a multi-method approach as part of an AR process. The method and the procedure of data collection are discussed next.

Figure 3.2 is an adapted version of a portrayal by Zuber-Skerrit, (1996:95) and describes one of the AR cycles (as initially shown in Figure 3.1) in more detail. For the purpose of the study, it also illustrates the methods of data collection and the sequence in which data was obtained.

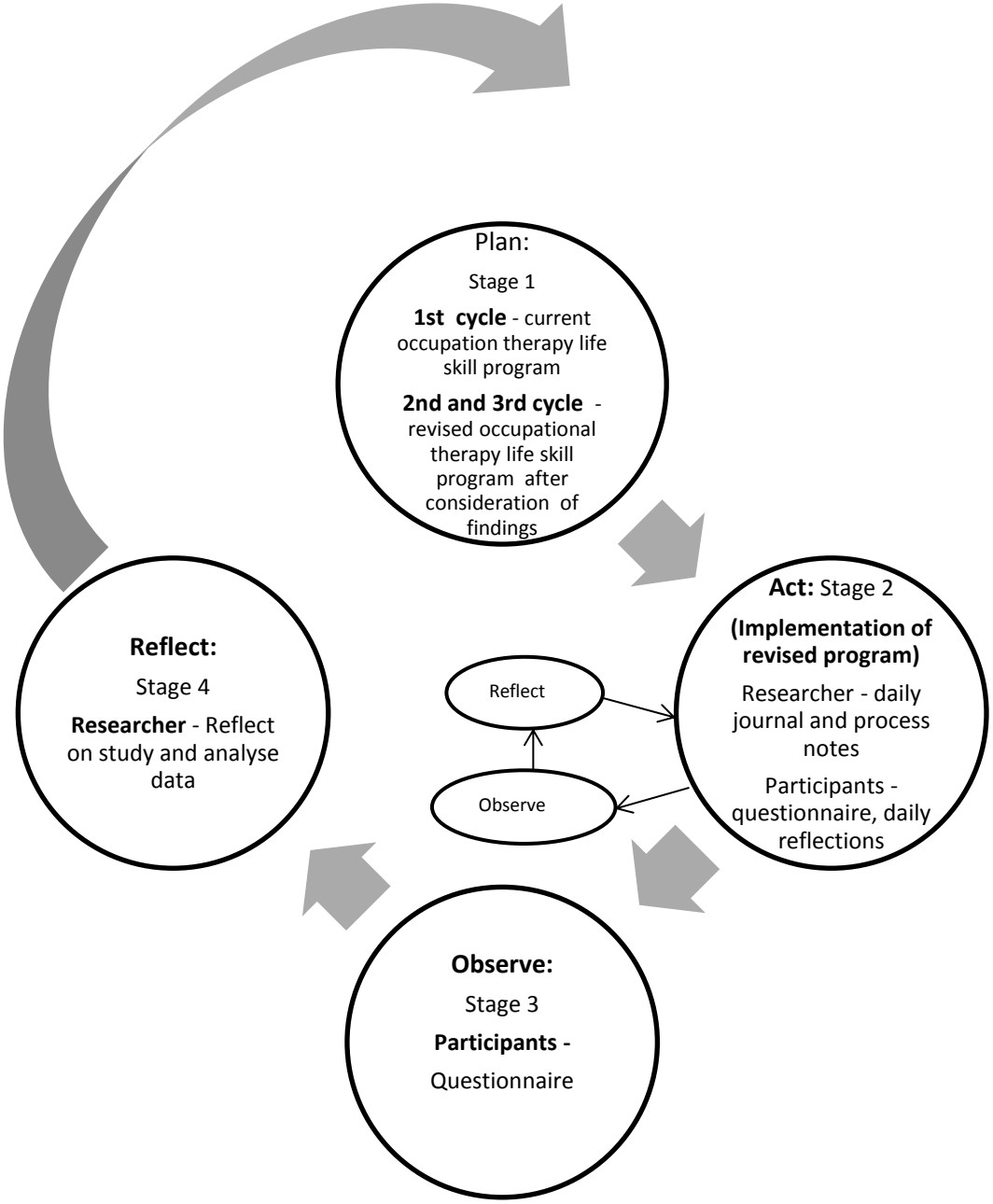


Figure 3.2: One cycle of the AR process (Adapted from Zuber-Skerrit 1996:95)

The AR cycles for the purpose of this study followed the outline of Zuber-Skerrit's initial cycles as shown in Figure 3.1, with the exception of Stage 2: Act, which also included continuous observation and reflection, while implementing a revised program as seen in Figure 3.2.

The methods of data collection presented in the figure above are explained in 3.4.1.

3.4.1 Method of data collection

Quantitative data collection methods (addressing objectives 1-3): The first questionnaire obtained background information as well as a checklist on reasons for admittance (Addendum F). The questionnaire was a self-report measure, since the participants should have been able to understand the questions of the questionnaire and answer them accordingly. The questionnaire was administered on the first/second day that the client joined the group, either in the group or individual orientation session. A questionnaire with closed questions and checklist options was used to be more time-efficient in comparison to answering open-ended questions. The checklist option also acknowledged that stakeholders were still adapting to the environment and to new medication on the first and second day after admittance when the first questionnaire needed to be completed. Therefore the completion of closed-ended questions required less effort than open-ended questions would. Daily written reflections by stakeholders, which included checklists, were also used to obtain data (Addendum G).

Qualitative data: Data were collected in various ways within the AR process, as presented in figure 3.2. Table 3.3 lists the data collection methods, the techniques used and the context, thus how the technique was used (Bowling 1997:316-317, McNiff *et al.* 1996:77-78, Schwalbach 2003:59-64, Winter 1996:15-16).

Table 3.3: Qualitative data collection methods – addressing objectives 1-3

Method	By whom	Techniques	Context
Stage 1 – Plan (Cycle 1) Notes	Researcher	Notes	Retrospective thoughts from previous life skill groups and also possible changes that could be made in the future (retrospective reflections and planning structured reflections).
Daily Journal	Researcher	Objective observations	How many stakeholders participated or didn't participate in discussions? Which factors influenced stakeholders' participation in the group? (Stage 2 – figure 3.2).
		Reflective comments/ self-reflection	Comments and feedback on the group: What worked well? What didn't work well? What could be done differently? Which external factors influenced the group? Self-reflection on my presentation. Suggestions for future groups. (Stage 2 - figure 3.2). (The same reflections used by the stakeholders were also used by the researcher to reflect on the group.)
		Feedback	General feedback from participants or other multidisciplinary team members on the OT groups. (Stage 2 – figure 3.2).
Process notes	Researcher	Record keeping	Individual notes (comments) on observations made by the researcher regarding individual stakeholders' reactions and participation in groups, and attendance (Stage 2 – figure 3.2).

I used different methods of data collecting to capture data on my observations. It was important for me to use these different methods in order to insure that triangulation, thus overlapping of results, occurred in order to contribute towards the trustworthiness of the study.

Table 3.4 identifies the methods, techniques used and the context it was used in to obtain data, both quantitative and qualitative within the same method. These collection methods applied to the first two cycles of the study.

Table 3.4: Quantitative and qualitative data collection methods (some data collecting documents contained qualitative as well as quantitative elements) – addressing objectives 1-3

Method	By whom	Techniques	Context
Daily reflections	Stakeholders	Written reflections which included open ended questions (qualitative) as well as a tick list (quantitative).	After each group session, stakeholders had the opportunity to reflect on the group: what they found positive and negative, comments on the presentation, content of group, knowledge and skills obtained, what could be done differently to improve the group, and external factors which influenced the session (Addendum G). (Stage 2 – Figure 3.2).
Questionnaire	Stakeholders	A questionnaire which included closed questions (quantitative), and open-ended questions (qualitative).	A questionnaire was completed by stakeholders at the end of the two-week period (Addendum H) (Stage 3 – Figure 3.2): this questionnaire focused on the impact of the life skill program on the participants (enablement), on the topics of the group sessions and on the client-centredness of the occupational therapy life skill program.

Table 3.4 shows that quantitative and qualitative research methods were used to complement each other by offering various sides of a process. It thus provided triangulation and contributed towards the trustworthiness of the study. The methods used focused on obtaining data on the reflections of stakeholders on their experience of the group, the impact of the life skill groups on stakeholders, the topics of group sessions and the client-centredness of the occupational therapy life skill program.

After the completion of Cycle 2 my insight into my groups expanded towards implementing some changes in order to improve the facilitation of groups and client-centredness. It was thus not necessary for another cycle to be done in exactly the same manner. In the reflection stage (Stage 4) of Cycle 2, changes regarding data collection were planned and then implemented in Cycle 3. This was done as insight also had to be gained on another aspect involving groups that had not been addressed satisfactorily/sufficiently by stakeholders, namely the content of group sessions. In other words, how could I better do in Cycle 3 what I did in Cycle 2? The changes that were made regarding data collection in Cycle 3 comprised the following:

- Daily reflections (Addendum G) were not completed after each group session as in Cycle 1 and 2, but only once a week after conclusion of the week's groups.

- An additional daily reflection (Addendum J) had to be completed by stakeholders after each group. These daily reflections were focused on the contents of the group, as very little information on the contents was obtained in the first two cycles.
- The last questionnaire (Addendum H) used in the first two cycles were excluded from the third cycle as saturation had been reached.

Table 3.5 shows the various questionnaires (Addendum F, G, H, J), listing the question numbers on that each questionnaire and clarifying what information/data the specific question required. It also shows what motivated/encouraged or formed the basis for the questions.

Table 3.5: Information on how the questionnaires were compiled

Addendum	Question Number	Information
F	1-5	Questions compiled to obtain background information on the stakeholder. The client-centred frame of reference formed the basis for questions in order to attain contextual congruence (cf. Figure 2.2).
F	6	This question focused on the reasons for the stakeholder's admission to the hospital. It was based on literature regarding mood disorders and its accompanying symptoms (thus on the general diagnosis of stakeholders). My experience and observations made as OT presenting group sessions in this setting also influenced questions. (cf.1.1) The client-centred frame of reference played a role as contextual congruence had to be addressed (cf. Figure 2.2).
G	1-6	The client-centred frame of reference formed the basis for these questions in order to explore enablement (cf. Figure2.2).
G	7	My experience as OT presenting group sessions in this setting influenced these questions, as they contained options identified through observation as possible factors **negatively** influencing the group process and experience. The clients' general diagnoses were also taken into account (cf. Figure 2.2).
G	8	My experience as OT presenting group sessions in this setting influenced these questions as they contained options identified through observation as possible factors **positively** influencing the group process and experience. The clients' general diagnoses were also taken into account and some questions were based on group psychotherapy theory (cf. Figure 2.2).
H	1-7	These questions focused on whether stakeholders gained knowledge and thus were enabled, due to the client-centred approach (cf. Figure 2.2)
H	8	Questions were based on literature of themes/topics presented by OTs in other South African psychiatric hospitals and on the themes and topics presented by OTs in the PC.
H	9	These questions were based on the client-centred frame of reference.
J	1-3	These questions were compiled to obtain information on the content of the groups.

From Table 3.5 it is clear that questions reflected current practice issues within the South African mental health context, as I had experienced. Questions 1-8 (Addendum G) specifically attempted to verify client experiences of the life skill groups; Question 8 (Addendum H) focused on the clients' perceptions of the themes of groups; and Question 9 (Addendum H) focused on the perceptions of clients on the client-centredness of the life skill groups.

The validity of questionnaires will be discussed in Table 3.8. A detailed description on how the above-mentioned data collection methods fit into the AR process follows in 3.4.2.

3.4.2 Procedures of data collection

Addendum K lists the chronological recording/summary of steps that were taken in order to ensure that an AR-directed (process-directed) data collection is obtained throughout the research project (cf. Figure 3.2).

Table 3.6 is a summary of the procedure of data collection (Addendum K) over the two-week stakeholder participation period based on the initial cyclical process displayed in Figure 3.2, thus one AR cycle. Stage 1 of the AR cycle occurred before the commencement of the two-week stakeholder participation stage of the study (Stage 2 – Act/Implement and 3 – Observe) as shown below. The summary below thus includes only the two-week stakeholder participation period of the cycle.

Table 3.6: Summary of procedure of data collection (stage 2 and 3)

Day	**Monday evening or Tuesday morning (week 1)**	**Tuesday – Thursday (week 1)**	**Monday – Thursday (week 2)**	**Thursday (week 2)**
AR cycle	**Stage 2: Act/Implement (Observation and reflection were done throughout stage 2 as part of the "acting" part of the AR cycle)**		**Stage 3: Observe**	
Procedure	Information session (or individual session) by the researcher where informed consent was obtained from potential stakeholders and a questionnaire completed by stakeholders.	Stakeholders Written reflection on each group, after group session or in their own time. Researcher Daily journal and process notes.	Stakeholders Written reflection on each group, after group session or in their own time. Researcher Daily journal and process notes.	Stakeholders Last group – second questionnaire completed.

From table 3.6 it is evident that throughout the two-week period, data was collaboratively obtained by stakeholders and the researcher. This data was acquired by observation and reflection. Stage 4 of the AR cycle followed after the conclusion of this two-week stakeholder participation stage. It comprised reflection on the study and analysis of data.

3.5 QUALITY CRITERIA FOR ADVANCING RIGOUR IN ACTION RESEARCH

Validity and reliability is generally understood to be the strength of the data of a study. Data should thus be sustainable, well-grounded and trustworthy. The rigour of the research process is summarised in Table 3.7 and includes the credibility, dependability, conformability and transferability of the data in the qualitative element of the study, according to Carpenter and Suto (2008:149), and Ebersohn, Eloff and Ferreira (2007:133).

Table 3.7: Strategies for credibility, transferability, dependability and confirmability (qualitative element)

Criteria	Question to be asked by the researcher (Carpenter & Suto 2008:149-150)	Methods used towards trustworthiness
Credibility	Can the data collected be accepted as true?	**Sufficient amount of data** I used various methods to collect data, leading to an extensive amount of raw data until saturation was reached. **Prolonged engagement with data** I collected all the data and spent an extended period of time analysing the data compiled (four months). **Thick description** The description of data was sufficient, "rich" and detailed in order for the reader to draw conclusions from the data presented. **Data triangulation and methodological triangulation** This was used by comparing data and using different methods of data collection in order to promote validation and confirmation that data is credible. **Researcher credibility** I have clinical experience and have been working in the described setting (presenting life skill groups) for 42 months at time of writing. I was also held accountable by study leaders and a critical friend, and had approval from the Ethics Committee of the Faculty of Health Sciences, UFS. **Feedback from others/"co-coders"** The two co-coders and study leaders were in agreement that I had made appropriate interpretations and drawn valid conclusions from the data. Co-coders were provided with literature and theory on coding (qualitative analysis).

Criteria	Question to be asked by the researcher (Carpenter & Suto 2008:149-150)	Methods used towards trustworthiness
Dependability	Will the data remain the same over a period of time?	**Transparent chain of evidence** I was supervised and obtained feedback from co-coders as explained above. I would not benefit from definite results (if the aim of the research were taken into account), and therefore objective results should be obtained. The method of data collection and instructions were carried out in exactly the same way in two of the cycles, and then altered for the third cycle. My comprehensive field notes.
Confirmability	Is data objective and neutral?	As discussed above, feedback from study leaders and a critical friend were used to confirm results. Reflexivity included methodologically self-critical accounts.
Transferability	Can data be applied to similar settings?	I endeavoured to give a detailed rich description of data collected during the study in order for data/guidelines to be used by therapists in similar settings. This was ensured through adequate description of sample and setting.

Table 3.7 shows the extent of the actions taken to ensure the trustworthiness of the study. Many of these actions were associated with the data obtained. I had to ensure that there was sufficient data, that enough time was spend on the data, that a sufficient and detailed description of data was completed and that data triangulation occurred.

The validity and reliability according to Creswell (2009:162), Katzellenbogen and Joubert (2007:117-119) and Pietersen and Maree (2007:215-218) are discussed in Table 3.8 as part of the quantitative element of the study.

Table 3.8: Strategies towards validity and reliability (quantitative element)

Criteria	Question asked	Measures towards reliability and validity
Validity	Does the research design and data obtained allow the researcher to reach accurate conclusions? How near is it to the truth? Does the measurement instrument measure what it is supposed to measure? (Katzellenbogen and Joubert 2007:117-119) (Pietersen and Maree 2007:216)	• In this questionnaire, closed-ended questions were used to prevent interpretation of answers. • The questionnaire was offered to participants in Afrikaans, which is the participants' language of preference, to exclude any misinterpretation of questions or answers. • Multiple indicators of a variable were used, e.g. two or more questions were used in the questionnaire to measure each aspect of a variable. • Hawthorne effect – this might have had an effect as clients knew they were part of the study and therefore might not have been honest when answering the questionnaire. Participants were however assured that they could be honest in the study as the aim of the study was to work towards best practice. • The same reflection was used by stakeholders and the researcher. • Questionnaires and reflections were completed by stakeholders either at the end of a group session (thus in a group setting) or in their free time (an individual setting). This was indicated on the questionnaire or reflection in order to clarify or show a difference in responses.
Reliability	Can the measurement used in the study and study results be applied to other contexts, and will the same result be obtained? (Katzellenbogen and Joubert 2007:117-119) (Pietersen and Maree 2007:216).	• If respondents were asked to write "yes" or "no" instead of more elaborate answers, interpretation is minimised, which maximises reliability (Joubert & Ehrlich, 2007). • Replication: in order to enable other researchers to replicate the study, I aimed to describe the study method (questionnaire) in exact detail.

It is apparent that, if possible, errors with regard to reliability and validity are anticipated, they may be better prevented. Table 3.9 therefore indicates possible errors that could occur in the study and the measures taken in an attempt to limit these to the minimum and to ensure validity and reliability.

The table below shows the techniques of measurement, possible measurement errors that might have occurred in the study, and explains the prevention measures established to assure the trustworthiness and validity of the study.

Table 3.9: Possible measurement errors and prevention measures

Technique	Possible error	Prevention of error
Reflection of stakeholders and observations of stakeholder actions made by the researcher.	I was known to the stakeholders and a therapist relationship was formed, which might have influenced the honesty of the clients' reflections and actions.	This may not have been a disadvantage, as stakeholders may have felt more comfortable and relaxed in sharing their feelings and perceptions with a therapist they knew. As this may also be a disadvantage, I reiterated the purpose of the study and the importance of stakeholders' honesty in order to improve the program. Stakeholders were assured that their responses would not influence the therapist-client relationship or influence my feelings. The reflections were part of AR where the stakeholders were actively involved, committed and informed of their role in the process, which should have fostered willingness and the responsibility to be honest and serious when completing reflections.
Reflection of stakeholders and observation by the researcher.	Acting as a tool of measurement, I may have been influenced in the interpretation and analysis of results by my own biases, ideologies and expectations.	I was held accountable for results of authentic quality by the study leaders and critical friend, who were part of the research process. I consciously attempted to identify my own biases and expectations for the study, and strived to limit the impact thereof on the study. A declaration/description of my biases follows: • I might be biased against negative feedback from stakeholders on my facilitation of life skill group sessions. • I might be biased against negative feedback from stakeholders on the group program or the PC. • I might be biased against uneducated stakeholders, finding feedback form educated stakeholders more valuable.
	Stakeholder participation and reflections might have been influenced by the effects of their medication or emotional state, e.g. side-effects of medication, or a client feeling upset after returning from a session with a psychologist, etc.	Questions on the stakeholder reflections indicated if there were any additional circumstances that influenced their experience of the group.
Reflection by stakeholders.	I might have been present when stakeholders complete their reflection of the group. I might have provided examples or led stakeholders to answer what they think were expected of them, rather than providing authentic answers.	As far as possible, I refrained from giving examples or leading stakeholders to answers. Stakeholders were only asked to answer the questions. When stakeholders felt unsure, I asked for an example from the stakeholders.

Technique	Possible error	Prevention of error
Reflection by stakeholders.	Stakeholders might not have provided ample (enough depth) information on the reflection due to time constraints.	I allowed sufficient time for stakeholders. If time was not sufficient, an additional time slot was arranged for the completion of the reflection, or stakeholders could finish it in their own time, when they chose to do it.
Process notes, reflection of researcher, self-reflection and comments on the group.	Acting as a tool of measurement, I might have been influenced in the interpretation and analysis of results by my own biases.	I was conscious of my own ideas and biases (I have declared/described my biases above). The data were analysed critically and I was held accountable by a critical friend and study leaders. I strived to limit the impact thereof on the study.
Questionnaires and reflection by stakeholders.	I collected questionnaires and reflections after the session, or later if stakeholders preferred to complete it in their own time.	This fact was indicated on the questionnaire or reflections in order to have clarified or showed a difference in responses.
Questions in the second questionnaire (Addendum H).	As some of the open-ended questions in the questionnaire had two parts, the possibility arose that stakeholders may only answer one part of the question.	I highlighted the fact that some of the questions were twofold and asked that sufficient information be given for these questions. The second part of the question was asked in order for stakeholders to give more extensive information or to explain their answer in the first part of the question. However, information gleaned from only one of the parts of a question was answered was still relevant and used as data.
The typing of data into an Excel spread sheet.	Inaccuracy or errors on the Excel spread sheet when I entered data.	This was limited by entering the same data onto two separate Excel spreadsheets. It was also checked by one of the co-coders and verified by the Department of Biostatistics, UFS, before being analysed.
The verbatim translation in the study from Afrikaans to English.	As the study population was Afrikaans-speaking, the study was performed in Afrikaans; stakeholders completed questionnaires and reflections in their mother tongue.	The verbatim collected in the study was freely translated to English for the purposes of the study, as the dissertation is presented in English. The Afrikaans verbatim is also displayed together with the English translation in order to ensure credibility of data.

The above table shows that many errors could occur due to the fact that I was acting as a tool of measurement and might have been influenced in my interpretation and analysis of data. The other factor that drew attention was that I was known to the stakeholders, which might have influenced their responses. However, by acknowledging these possible errors and taking preventative action, the trustworthiness and validity of the study was safeguarded.

3.6 ANALYSIS OF DATA

Thematic analysis was used in this study for the analysis of qualitative data. Through this approach, the researcher does the following: reduce data to 'manageable units through forms

of coding or labeling chunks of text and then displaying these data in new ways' (Carpenter & Suto 2008:48). Sources on qualitative analysis provide similar guidelines for thematic analysis, although terminology often shows slight differences. (Carpenter & Suto 2008:115; Creswell 2009:186; Creswell 2012:237 & 238;Polit & Beck 2006:398; Ritchie, Spencer & O'Connor 2003:237; Saldana 2009:3; Schwalbach 2003; 77-78).

The data in this study were obtained from daily journal entries, process notes and reflections by the stakeholders. Throughout and after each AR cycle, data were analysed. The steps outlined in Table 3.10 were used in this AR study to direct the analysis of the qualitative data, mainly guided by Schwalbach (2003:77-78), who provides specific guidelines for qualitative analysis of data generated by action research. Guidelines from other authors, which were found to be compatible with Schwalbach's process of analysis, were also included as supporting evidence for this process. Table 3.10 details each step in the analysis process and further describe each step, supporting the analysis of data. It also describes the actions undertaken in the particular step and lists where it was used within the AR cycle.

Table 3.10: Analyses of qualitative data

Step	Description	Where does it fit in the AR cycles as seen in this study?
Review your research question (Braun and Clarke, 2006:77-101; Schwalbach 2003:77-78)	Make sure that this was the question for which data were obtained. The question can be revised or rephrased in order to focus on the problem that has been studied.	Before commencement of the study and after the preparation phase of the study. Also, throughout the process of data analysis, the researcher will always bear the research question in mind.
Familiarising with data (Schwalbach 2003:77-78)	Transcribing data, reading and rereading the data noting down initial ideas.	Reading of journal and process notes; as well as the reflections of stakeholders
Read through the data and look for patterns and themes (Schwalbach 2003:77-78)	Investigate what recurring patterns and themes are evident.	Stage 4 of every cycle – looking at the completed reflections of stakeholders, as well as my own journal and process notes.
Generate initial codes (Braun and Clarke, 2006:77-101; De Vos 2005a:337; Schwalbach 2003:77-78)	Code categories as they start to appear. Use coloured markers or cut data and place these into different folders. Continue coding as other categories emerge (for example, if respondents make comments about uncomfortable seating, it may have been labelled as a code).	Stage 4 of every cycle – reading the completed reflections of stakeholders, as well as my own journal and process notes.
Examine categories (Flick 2002; Schwalbach 2003:77-78)	Codes relating to each other (for example 'uncomfortable seating' and 'poor airconditioning' may be grouped together as a category. Ask whether each category has enough data, if the evidence is strong and if there is enough data to draw a conclusion. If	Stage 4 of every cycle - reading the completed reflections of stakeholders, as well as my own journal and process notes.

	the answer is no, more data must be collected. The question has to be asked if insight has been obtained to better the next cycle.	
Searching for themes, define and name these themes (Creswell 2009:189; Creswell 2012:245-248; Saldaña 2009:3; Schwalbach 2003:77-78)	Collating codes into potential themes, gathering all data relevant to each potential theme (for example, the codes mentioned previously together as a category – uncomfortable seating and poor airconditioning - may now relate to other similar codes and categories and be grouped together as a theme such as 'external factors influencing the experience of stakeholders').	Stage 4
Reviewing themes ((Braun and Clarke, 2006:77-101; Creswell 2009:189)	Checking if the themes are in line with the codes, and then draw the themes as identified in the previous step, generating a thematic map.	Stage 4
Look for discrepant cases (Schwalbach 2003:77-78)	Look for evidence that is inconsistent with the majority of your data. In this study no discrepancies were found.	Stage 4
Producing the report (Braun and Clarke, 2006:77-101; Creswell 2009:189)	The final opportunity for analysis, relating back to the analysis of the reseach question and literature, producing a report of the analysis.	Writing the dissertation to report the data as lain out in the thematic map.

These steps of data analysis were followed strictly (although initially independently from each other) by both the researcher and two co-coders, in order to ensure the credibility, conformability and dependability of the study. Following the coding done by all three analysts (researcher and co-coders), themes were confirmed and agreed upon during a meeting.

Quantitative data analyses were completed by the Department of Biostatistics, UFS, after I had entered data onto a Microsoft Excel spread sheet and it had been verified by a co-coder. The following data were obtained by analysis (stage 2, 3 and 4 of AR cycle):

- Descriptive statistics, namely frequencies and percentages for categorical data, and means and standard deviations or medians and percentiles for continuous data, were calculated.

3.7 ETHICAL ASPECTS

Guidelines for ethical conduct were followed during the planning and execution of the study as described by Leedy and Ormrod (2010:101-104) and Strydom (2005b:75).

In brief, the following ethical considerations were taken into account:

- Informed consent;
- Protection from harm of participants;
- Privacy and confidentiality of participants; and
- No deception of participants or professional colleagues by the researcher.

The following steps were taken in the study to attain the above-mentioned guidelines and principles:

- Firstly, written consent for the research project was obtained from the management of the psychiatric clinic, the owner of the occupational therapy practice, the matron of the PC, and all referring doctors and psychologists. An information letter, which included detailed information on the study, its purpose, and methods of data collection and planned outcomes, was given to the above-mentioned parties (Addendum C, D, E).
- The protocol for the study was submitted to and approved by the Ethics Committee of the Faculty of Health Sciences of the University of the Free State (ECUFSW136/2013).
- The study was not expected to pose any potential risk or physical or emotional discomfort to the stakeholders; I thus did not have to plan any protection from harm as an ethical measure.
- The occupational therapy group sessions and all written information to stakeholders were conducted in Afrikaans, as one of the inclusion criteria for stakeholders was that Afrikaans had to be their language of preference.
- On the commencement of the study a discussion was held with the potential stakeholders of the study. During the discussion I gave *detailed information on the study, its purpose, method of data collection and planned outcomes.* I was truthful with stakeholders about the purpose of the study, and the stakeholders' rights – including their right to privacy, the right of the subjects to refuse participation, or to withdraw from the study at any given time during the study – and about the results after completion of the study. However, I was attentive to not disclose personal information that could have influenced stakeholders' responses, and ultimately the results of the study.
- Informed consent was then obtained from stakeholders (Addendum B) and they received an information letter which again included *detailed information on the study, its purpose*

and planned outcomes, method of data collection and their rights as stakeholders as discussed above. Stakeholders had to understand that participation was strictly voluntary.

- Although information was not anonymous, it was kept confidential and will be used for research purposes only by me.
- Stakeholders were informed of the researcher's intention to publish the results via an accredited journal or the possibility of a presentation of the study at a congress or occupational therapy gathering/meeting.
- Stakeholders were offered the opportunity to receive information on the results of the study. My details were available for stakeholders to contact me for the results of the study, should they be interested at a later stage.
- Stakeholders may contact me or the Ethics Committee of the UFS, should they have any queries.
- The name of the PC will not occur in any publications in order to protect the clinic from unfair and uninformed criticism, and to protect the identity of staff members and patients.
- The PC, the occupational therapy practice in question, multidisciplinary team members and the group program were not compromised at any time during the study.
- Assistant researchers, i.e. study leaders, colleagues, co-coders and critical friend, were also expected to comply with the same ethical guidelines as described in this proposal.

3.8 SUMMARY

This chapter described the research methodology for this study and focused on AR with a multi-method approach. Mostly qualitative elements through daily reflection activities for stakeholders and the group presenter, as well as some quantitative elements such as checklists, were used to obtain the data for the study. Convenience sampling within the qualitative non-probability framework was used. The sample included all clients (potential stakeholders) who attended my Afrikaans group sessions and matched the inclusion criteria (cf. 3.3.2) for the study. The researcher completed three AR cycles in the study. This means that three different groups of stakeholders who attended my two-week occupational therapy life skill program within the execution period of four months were included in the study. Quantitative data analyses were completed by the Department of Biostatistics, UFS. Multifaceted thematic analysis was used for the analysis of qualitative data. Quality criteria for advancing rigour in action research were included and the ethical considerations that were taken into account during the planning and execution of the study were described.

Chapter 4 will present the findings of the data obtained in the study.

CHAPTER 4

FINDINGS

In this chapter the findings are presented in order to answer the research question for this study:

> How could I gain insight into my current facilitation of a predetermined/structured two-week life skill program in order to continually address best client-centred practice for the clients I serve?

4.1 PRESENTATION OF FINDINGS

The evolving action research process explained in Chapter 3 generated an extensive amount of findings. As different methods were applied to collect data, the trustworthiness of findings was supported not only by data triangulation, but also due to an overlap in results. Verbatim quotes (Creswell 2009:191) are utilised to enrich the presentation of data. The data generated and analysed during each cycle are organised in Table 4.1 to highlight the associated methodology, instruments and techniques utilised, and where within the dissertation the analysed findings can be viewed in totality. Within this chapter, verbatim quotes will be indicated using italics; these have been translated freely from Afrikaans to English by myself and checked by a co-coder.

Table 4.1: Data obtained during the study

Data collection methodology	Method	Techniques and by who	Context
Qualitative	**Stage 1 – Plan (Cycle 1) Notes**	Notes by the researcher	Retrospective thoughts from previous life skill group sessions, as well as possible changes that could be made in the future (retrospective reflections and planning structured reflections).
Quantitative	**First questionnaire**	A questionnaire, which included closed questions and checklist, was completed by stakeholders.	The questionnaire was administered on the first/second day that the client joined the group, either in the group or individual orientation session (Addendum F).
	Daily Journal	My objective observations	How many stakeholders participated or didn't participate in discussions? Which factors influenced stakeholders' participation in the group?
		My reflective comments/ self-reflection	Comments and feedback on the group session: What worked well? What didn't work well? What could be done differently? Which external factors influenced the group? Self-reflection on the researcher's presentation. Suggestions for future group sessions: I used the same reflections as the stakeholders to reflect on the group sessions.
		Feedback from stakeholders or other multidisciplinary team members	General feedback from participants or other multidisciplinary team members on the occupational therapy groups.
	Process notes	My record-keeping	My individual notes (comments) on observations regarding individual stakeholders' reactions and participation in groups, and attendance.
Quantitative and qualitative	**Daily reflections**	Written reflections, which included open-ended questions (qualitative) as well as a checklist (quantitative) by the stakeholders.	After each group session, stakeholders had the opportunity to reflect on the session: what they found positive and negative; comments on the presentation; content of group; knowledge and skills obtained; what could be done differently to improve the group; and external factors which influenced the session (Addendum G).
	Last questionnaire	A questionnaire, which included closed (quantitative) and open-ended (qualitative) questions by stakeholders.	A questionnaire was completed by stakeholders at the end of the two-week period (Addendum H). This questionnaire focused on the impact of the life skill program on the participants (enablement); on the topics of the groups; and on the client-centredness of the occupational therapy life skill program.

The procedural course of collecting quantitative and qualitative data is evident in Table 4.1. During Cycle 1 and Cycle 2, a two-week period each, stakeholders completed a first

questionnaire at the beginning of the two-week period; daily reflections (one or two per day) depending on the amount of group sessions facilitated by the researcher; and a final questionnaire at the end of the two-week period.

Throughout every cycle I completed daily process notes on each stakeholder; I made personal daily journal entries that included general observations of the group process and events directly prior, during or after the group; I made reflective comments/self-reflection on my role in the group; and I noted feedback from stakeholders or other multidisciplinary team members.

After the first two cycles, procedural changes were incorporated for Cycle 3. Daily reflections (Addendum G) were not completed after each group as in Cycle 1 and 2, but only once a week after the conclusion of the week's groups. In Cycle 3 an additional daily reflection (Addendum J) was introduced to obtain specific information. This included detailed information on the stakeholders' experience of the content of the group and the activities used in the sessions, for example worksheets or projective techniques, as it was not sufficiently addressed in reflections by stakeholders in Cycle 1 and 2 and more information was thus needed to assure triangulation. The last questionnaire (Addendum H) used in the first two cycles was excluded from the third cycle, as Cycle 2 confirmed findings form Cycle 1 and data saturation was satisfactory.

Data collection, as set out in Table 4.1, indicated that the questionnaires and reflections assisted in obtaining information from stakeholders on who the stakeholders were, their experience of the group (impact of the life skill group on stakeholders including the enablement and satisfaction of stakeholder), internal factors (including topics of life skill groups) and external factors influencing the group and the client-centredness of the occupational therapy life skill program.

As stated at the beginning of this chapter, the action research approach and collaborative nature of the study generated a vast amount of data. The wide range of these findings, representing both an insider (viewpoint of the clients) and outsider (my own)) perspective, is selectively presented in order to address the objectives of the study (cf. 1.4.1), namely:

- Gain insight into how stakeholders perceive the contents and facilitation of the life skill program to support their individual needs during admittance (client-centredness of life skill program and enablement of stakeholders).

- Cultivate personal reflexivity and gain a greater understanding/insight of how **external indicators** may influence the life skill program.
- Cultivate personal reflexivity and gain a greater understanding/insight of how **internal indicators** may influence the life skill program.

The action research process revealed three overarching themes within the findings. Firstly, I gained insight into who the people attending my groups were; secondly, my understanding of both external and internal indicators that have an impact on the client-centred nature and curative processes of occupational therapy groups was expanded; and thirdly, I was more informed about the experienced immediate effect of the life skills program on the stakeholders. These themes direct the presentation of the findings and each theme is supported by incorporating findings from all relevant cycles. Additional data are included in the addendums.

4.2 AN ACTION RESEARCH JOURNEY OF DISCOVERY

The initial phase of the journey was associated mostly with a first-person inquiry that focused on me questioning my own assumptions and reflecting on my occupational therapy groups in general. I realised that I needed a clearer indication of who the clients were and then to understand what their perspectives were – perspectives about the impact of the life skills program and on internal and external indicators that influenced them during my group sessions.

4.2.1 Retrospective reflection in anticipation of planning the action research process

In the first stage of Cycle 1, I retrospectively reflected on my previous life skill groups (cf. 1.1). Armed with this pre-understanding, I actively sought a structured process that would continue to guide reflections and actions. This procedure initiated engagement in an ongoing action research process and the formal planning phase for stage 1 of the first cycle (cf. 3.2.). The method of data collection was developed, as discussed in detail in chapter 3 (cf. 3.4.1, Table 3.3-3.4).

I was not alone during this journey of discovery, as clients were involved as active collaborators to support me in understanding who the people were who attended my groups. Access to basic demographic information indicated the age, gender, level of education and employment status of the stakeholders, as well as reasons for their admittance.

4.2.2 Who are the stakeholders?

Getting to know the stakeholders: In the anticipatory reflection stage of the study (Stage 1, Cycle 1) I realised that I only met the group members who would be attending my groups for the following two weeks at the orientation session on Mondays. As it was not possible to have individual interviews with members or to read their individual files before the commencement of the psycho-social group program, I did not have any background information on these clients, nor did I understand why they were admitted. I therefore found it initially difficult to relate to clients, or to know when to be sensitive regarding certain subjects. I was also less likely to use relevant examples in the groups. I got to know the clients in my group better as the week continued and had time to read the files; however, the files often did not contain much information. This insider perspective directed the development of a self-administrated questionnaire for stakeholders (with closed questions and checklist – Addendum F) that would generate demographic information on the group members as well as supply a reason for their admittance.

Research cycles were completed over the course of four months (cf. Table 4.1). All clients fitting the inclusion criteria during this period were invited to participate in the study and those who consented became collaborative partners in this journey. The stakeholder profiles for Cycle 1 and Cycle 2 is delineated in Table 4.2.

Table 4.2: Stakeholder profiles

Demographics	Cycle 1 (n=10)	Cycle 2 (n= 20)	Cycle 3 (n=9)
Gender	Male = 4 Female = 6	Male = 7 Female = 13	Male = 1 Female = 8
Age range	20 – 56	20 – 61	21 – 65
Highest qualification	Grade 10 = 2 Grade 12 = 4 Diploma = 1 Degree = 3	Grade 10 = 2 Grade 11 = 1 Grade 11 and diploma = 1 Grade 12 = 8 Diploma = 4 Degree = 3 Master degree = 1	Grade 11 = 2 Grade 12 = 3 Diploma = 1 Degree = 3
Occupation	Homemakers = 4 Teachers = 3 Day care mother = 1 Correctional official = 1 Student = 1	Admin-related = 4 Retired (teacher) = 1 Assistant director = 1 Manager = 1 Bookkeeper = 1 Prospector = 1 Community development = 1 Homemaker= 1 Receptionist = 1 Police official = 2 Receivables administrator = 1 Silo manager = 1 Switchboard operator = 1 Sales assistant = 1 Nursing = 1 Unemployed = 1	Occupational therapist = 1 Payroll administrator = 1 Homemaker = 3 Medical technologist = 1 Receptionist = 1 Student = 1 Pensioner = 1
Geographical areas: Northern Cape	5	4	2
Free State	2	11	5
North West	2	1	2
Eastern Cape	1	2	0
Gauteng	0	2	0

The group of stakeholders in Cycle 1 consisted of 10 stakeholders and Cycle 3 of nine stakeholders. Cycle 2 consisted of 20 stakeholders, which was an unusually large group, as our groups were normally averaging five to 12 members. All three groups consisted of more women than men and the ages of stakeholders ranged between 20 and 65 years.

It is evident that the level of education and occupations of the stakeholders in all three groups varied considerably. In Cycle 1, six of the 10 members of the group had a lower education level. Similarly, Cycle 2 confirmed the range of clients attending the PC, as this group presented with four stakeholders who had not completed their schooling, (compared to two in Cycle 1) and eight who completed schooling but did not receive any additional training (compared to four in Cycle 1). Cycle 3 followed the same trend as two stakeholders completed Grade 11 and three completed Grade 12. Stakeholders with tertiary qualifications were in the

minority with four of ten in Cycle 1 compared to eight out of 20 in Cycle 2 and four out of nine in Cycle 3.

Stakeholders' employment status also varied considerably, with occupations including administrative positions, teaching and homemaking. Stakeholders also resided in various areas of the country. Hospital statistics from the three cycles confirmed that clients admitted to the PC hailed predominantly from the Free State, Northern Cape, and North West Province.

Insider perspectives (due to the completion of the questionnaire used – see Addendum F) and hospital statistics confirmed the background and stakeholders' areas of originated. Reviewing this information from the questionnaires enabled me as the outsider to facilitate my life skill groups by accommodating the stakeholders' different levels of functioning and promoting the group process (cf. 1.1.). It also guided me in terms of what examples to use during group discussions, e.g. I specifically considered issues associated with "informal" employment arrangements of homemakers to encourage their participation in situations that often tended to focus more on issues related to formal employment.

Impact on research process: During Cycle 1 I realised that some of the stakeholders found it difficult to express themselves by way of writing and seemed to be more confident answering closed-ended questions and checklists rather than the open-ended questions, as the closed-ended questions and checklists were completed more comprehensively. Open-ended questions were seldom completed or had answers of one or two words. Therefore the questionnaire used in Cycle 1 was updated during Cycle 2 by one change made to clarify question 3. The question, "What is your highest qualification/level of education?" especially resulted in vague answers and information had to be clarified verbally with the stakeholders. In Cycle 2 an adjustment was incorporated to include examples in brackets (e.g. Gr 10 school, Diploma, University degree etc.) to guide stakeholders.

Understanding why stakeholders were admitted: As mentioned previously, the first questionnaire included a section to verify the reason for admittance of stakeholders.

The stakeholders in Cycle 1, 2 and 3 respectively had selected options indicated in Figure 4.1 as the reasons for their admittance to the PC.

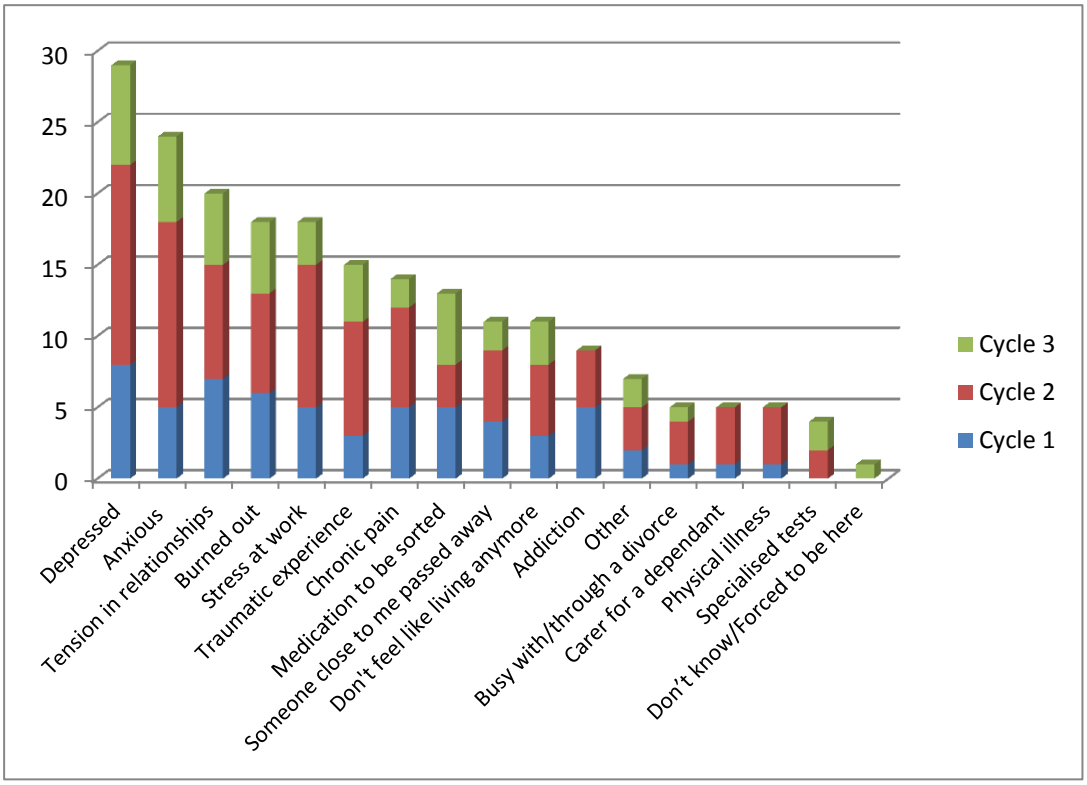


Figure 4.1: Reasons for admission - Cycle 1, 2 and 3

The above graph indicates the potential reasons that stakeholders respectively identified as part of the reasons for their admission to the PC. According to the data presented in the graph it seems that depression was the most predominant reason for admission for all three groups. Anxiety; tension in relationships; stress at work; burn-out; and suicidal ideation ("I don't feel like living anymore") also seemed to be quite common reasons for admission in all three cycles of the study. Stressful life events such as someone close to a stakeholder passing away; a traumatic experience; divorce; chronic pain; or being a full-time caregiver were also indicated. In Cycle 1 and 2 addiction was more prevalent than in Cycle 3, whereas specialised tests (e.g. EEG to test for epilepsy or brain scans to find the reason for a patient showing symptoms of dementia) and stakeholders being forced to be at the PC (e.g. a patient who is manic due to bipolar disorder and does not want help but needs it) were more prevalent in Cycle 3 than in Cycles 1 and 2.

This contextual information served as background information, enabling me to use relevant examples in my groups while also supporting me in gaining an understanding and empathy for the group members. This was confirmed by quantitative data given by stakeholders in their daily reflections as 146 out of 220 reflections indicated that stakeholders could identify with the examples used in the life skill groups. This aspect was more often indicated in Cycle 1 and 3

than in Cycle 2. It also made me aware of stakeholders with chronic pain and I was more sensitive to address needs associated with physical comfort during the group process. The information highlighted which stakeholders were prone to anxiety and I could facilitate structure and security for group members by providing sufficient information, contracting with stakeholders and compiling group rules in partnership with stakeholders. The data also indicated mutually/commonly shared problems in the group and I could spend more time or focus examples on those issues throughout the cycle; for example, interpersonal skills (communication, conflict management, assertiveness) was an area that many clients reported on, tension in their relationships, or problems with addiction. Consequently, access to this data aided me in building a therapeutic relationship with stakeholders.

'Being informed' and 'having insight' ensured a client-centred approach that was not only reflected in my confidence in our therapeutic relationship, but this was also confirmed by my stakeholders in the final questionnaire (during Cycle 1 and 2). Table 4.3 indicates that 17 out of 18 stakeholders agreed to the question of whether I had addressed their needs based on my understanding of who they are. As all but one stakeholder concurred on this matter, this question didn't need further exploration as saturation was reached and the question was not again included in Cycle 3.

Table 4.3: Were stakeholders' needs addressed?

Cycle	Question	Yes	To some degree	No
Cycle 1	Do you think the occupational therapist understood your specific situation and roles you take on etc., and took it into account during groups?	4	1	0
Cycle 2		13	0	0

A basic background of stakeholders assisted me in adapting group presentations to cater for specific and individual needs and is supported by stakeholders' identification of external factors that impacted on the therapeutic quality of their life skill groups. A description of these external indicators will now follow.

4.2.3 External indicators

One of the objectives of this study was to gain a greater understanding/insight of how external indicators may influence my life skill group sessions. In this study, external indicators referred to factors not directly associated with the group process (I am involved in) and which I do not have any control over, e.g. client's side-effects experienced due to medication and the

interruption of groups by other team members. The following data will include different external indicators that either had a negative or positive influence on my life skill groups. The following data will include attendance of groups and positive and negative external indicators from an insider and outsider perspective.

4.2.3.1 Attendance of groups

The following table lists the topics for week 1 and 2 respectively for the three AR cycles. It shows how many stakeholders attended the groups and how many reflections were completed.

Table 4.4: Week 1 – Attendance, completion of reflections and relevance of topic

Number and sequence of groups	Topic	Attended (n)	Completed reflections	Attended (n)	Completed reflections	Attended (n)	Completed reflections
		Cycle 1 (n=10)		Cycle 2 (n=20)		Cycle 3 (n=9)	
1	Stress	6	5	9	9	7	No reflections administered
2	Self-knowledge	8	8	12	12	8	8
3	Self-image 1	7	7	13	13	7	7
4	Self-image 2	8	8	15	15	8	8
5	Stress and my senses	8	8	12	12	7	7

Insider perspective: Ten stakeholders participated in Cycle 1 of the study. The data presented in the table above shows that the 10 stakeholders were never all present in the groups at the same time, with eight stakeholders being the optimum number of attendees. This was also the case in Cycle 2 as 20 stakeholders participated in Cycle 2, with the most stakeholders in a group being 15. Cycle 3 had nine stakeholders but the groups never exceeded eight members.

The attendance for the first groups in all cycles seemed to be less than some of the other groups later in the week, possibly because many stakeholders had to see their psychiatrist for the first time and the first appointments always took longer than usual; this caused stakeholders to miss a big part of the group session, or to not to attend at all. Another possibility is that patients were admitted a day or two after the start of a two week cycle; thus not attending the first group sessions. And finally, patients in the PC often report severe side-effects of new treatment regimes early in their admissions, causing them to miss the first group sessions.

Impact on the research process: In Cycle 1, one reflection was returned without being completed. Thereafter I made sure that all reflections that were returned to me were completed as seen in Table 4.4 and Table 4.5. It was difficult to collect reflections not completed in the group, so I then tried to get stakeholders to complete reflections as far as possible during the session. From this point onwards, all reflections handed out were completed and returned. In the first cycle I also realised that question 2-6 of the reflections (these were all open-ended questions), were not answered well – stakeholders only used one word or left it unanswered. I considered that the wording might influence the response; thus the wording was changed and the sentences shortened and made more user-friendly, e.g. "I learned that…" or "It was positive that…" (Addendum I).

Table 4.5 lists the week 2 stakeholder attendance of all three cycles.

Table 4.5: Week 2 – Attendance, completion of reflections

Number of group	Topic	Attended (n)	Completed reflections	Attended (n)	Completed reflections	Attended (n)	Completed reflections
		Cycle 1 (n=6)		Cycle 2 (n=16)		Cycle 3 (n=9)	
6	Assertiveness 1	6	6	15	15	6	6
7	Assertiveness 2	6	6	10	10	4	4
8	Stress and my personality	5	5	11	11	9	9
9	Self-image 3	6	6	13	13	6	6
10	Conflict and assertiveness techniques	5	5	13	13	4	4
11	Anxiety	3	3	6	6	6	6
12	Day planning and stress management	5	5	12	12	2	2

Insider perspective: In the second week of the first cycle the group consisted of only six stakeholders, as three of the stakeholders of the first week had been discharged and one transferred to a medical hospital. Cycle 2 also had only 16 stakeholders in week 2 compared to 20 in week 1.

Outsider perspective: My experience of clients being discharged after completing only one week of the psycho-social program is negative, as clients have then been made aware of their behaviour, thinking patterns, way of communicating and other problems regarding life skills, and they have started to gain knowledge – but often have not been enabled as many techniques are addressed only in the second week of the program. It also influenced the cohesion in the group. According to Farley (1998:57-59) the length of stay can be an obstacle towards an effective psychotherapeutic program as one week stay is too short. In cycle 3, all

nine stakeholders from week 1 also attended week 2, but as the week progressed, stakeholders were discharged; it was the holiday season and the week before Christmas, and stakeholders seemed to want to go home as soon as possible. Due to this, only two stakeholders attended the last occupational therapy life skill group and consequently only two last questionnaires were completed.

Table 4.5 shows that the general attendance of groups in week 2 was good, except for the group session on anxiety. Retrospective reflections on discussions of the program content with colleagues also indicated that the anxiety group session was very often not well attended. We could not identify the reasons for this, but speculated whether only clients who experience anxiety attended the group, or whether this time slot fell within a time of day that many psychiatrists preferred for individual sessions with their clients. A constructive way of utilising the information on poor attendance – as this was evident in both Cycle 1 and 2 – would have been to trail another topic while still ensuring that there was information in the hand-out/workbook on anxiety. However, the set structure of the program at the PC does not allow for changes and this was not an option I could pursue at the time of the research. I made a note that this aspect would need to be brought to the attention of the group program management team at the PC. Another option I considered was to change the name of the group session, or to give more information regarding the session to the stakeholders that would encourage a more informed choice for attendance/non-attendance.

When taking into account the context within which my life skill groups are facilitated, it is apparent that more factors are possibly influencing these groups other that my own facilitation and what happens inside the group. The following data will thus focus on external factors in order to establish the effect of these on the stakeholders experience on the life skill groups.

4.2.3.2 External indicators that had a <u>negative influence</u> on the stakeholders' experience of the life skill groups

Table 4.6 shows the aspects that stakeholders identified in their daily reflections (quantitative data) as potentially having a negative influence on their experience of the group. The total amount of reflections that was completed in Cycle 1 was 73, with 140 in Cycle 2, and only 7 in Cycle 3, as it was only completed once at the end of a week (thus twice in Cycle 3).

Table 4.6: External aspects that had a negative influence on stakeholders' experience of life skill groups.

Negative aspects	Cycle 1 (Total of 73 reflections completed)	Cycle 2 (Total of 140 reflections completed)	Cycle 3 (Total of 7 reflections completed)	(Total of 220 Reflections)
	Number of times aspect was indicated	Number of times aspect was indicated	Number of times aspect was indicated	Total over the three cycles
I am worried about something outside of the group and think of it often.	7	36	3	46
The interruption of group sessions when a fellow stakeholder was called for another appointment (with a psychiatrist or psychologist).	15	29	1	45
The side-effects of my medication.	22	16	4	42
My psychical condition (illness/pain)	14	23	1	38
I find it hard to focus and to concentrate.	10	21	3	34
The breaks are too short.	0	29	2	31
I am physically uncomfortable.	0	24	3	27
I felt anxious, upset or depressed.	4	19	3	26
I could not attend the group or could only attend a part of the group due to other appointments.	8	11	3	22
I didn't sleep at all or didn't sleep well last night.	11	4	1	16

Table 4.6 displays the total number of times that an aspect was mentioned by my stakeholders (insiders) within the specific cycle. It also indicates the overall total of negative aspects noted by stakeholders throughout the study.

The ten negative aspects indicated the most over the three cycles of the study are discussed accordingly in order of significance from the highest to the lowest scores. Initially the insider perspective, especially qualitative data, is used to support numerical findings, and this is expanded upon by my reflections and on outsiders' perspective on the situation.

(a) I'm worried about something outside of the group

Insider perspective: In Cycle 1 stakeholders reported seven times that their participation/experience of the group was influenced by things (worries) outside of the group. It escalated towards Cycle 2 as this aspect was indicated 36 times. It was also noted three times in cycle 3.

Outsider perspective: In my reflections, the following explanations were considered on why stakeholders nominated this aspect so frequently. These reasons might be that worries or issues that the stakeholder struggles with might now be more on the foreground as they are now in therapy and their trauma or problems are addressed. It is inevitable that stakeholders might feel upset after a session that addressed these issues. They might also receive a phone call from a person/institution that causes stress in their lives or from home as they are away from home and their families for two weeks. In Cycle 1, for example, one stakeholder indicated this aspect five times – it might thus be possible that this specific stakeholder found it difficult to focus on the group due to their own problems/worries.

(b) The interruption of groups

Insider perspective: This aspect was the second-most indicated external factor impacting negatively on the therapeutic process over the extent of the study for life skills groups. It also corresponded with one of the themes identified during qualitative data analysis of the reflections from insiders in Cycle 1 and 2, as stakeholders viewed the interruption of groups very negatively.

Interruptions by doctors who want to see patients"
"Interruption of groups"
"It is bad if you have to go to the doctor in the middle of the group"
"The interruptions of sessions are negative"

The following suggestion was also made by stakeholders in Cycle 1:

> *"Make a timetable for doctor's appointments in order for appointments to not clash with group sessions"*

One stakeholder in Cycle 1 also remarked that noise on the balcony disrupted the group and they experienced it as negative.

> *"Another class walked on the balcony and made a noise"*

Outsider perspective: Distractions or interruptions of the group were often noted in my own reflections of the group. The reasons I recorded for interruptions were wide-ranging and included team members interrupting groups to acquire stakeholders for other appointments; stakeholders leaving for another appointment; a stakeholder who left the group due to a migraine; the group next door doing a part of their session on the balcony that diverted stakeholders' attention; and various forms of noise from outside of the group room. My experience was confirmed by that of stakeholder perceptions and disruptions of the skills group, and it was acknowledged by us all as problematic and impacting on the therapeutic process.

Impact on research process: After the problem of noise in particular was identified by both the stakeholders and me in the first cycle, this aspect was included as an item on the checklist of the daily reflections, reflected in quantitative data as from cycle 2; however, stakeholders in Cycles 2 and 3 did not find noise a major concern regarding the interruption of groups as the item was not selected at all by any of the 20 stakeholders in Cycle 2. It was indicated as a problem by only two stakeholders in Cycle 3.

(c) The side effects of my medication

Insider perspective: This aspect was identified the most by stakeholders in Cycle 1 and highlighted more specifically during the first week of the cycle. In comparison, Cycle 2 had 16 indications and Cycle 3 had four indications, totalling 42 indications, which is the third highest aspect indicated.

Outsider perspective: Stakeholders often complained that they do not feel well due to the side-effects of their medication in their first week of admission. They indicated that they suffered from, among other things, feeling sleepy, nauseous, dizzy, having headaches or finding it difficult to concentrate. It thus confirms the fact that side-effects had a negative impact on the stakeholders' experience of the group session.

(d) My physical condition

Insider perspective: This aspect was selected 38 times over the course of the study. It seemed that stakeholders struggling with physical conditions and illness also selected this aspect when they completed a reflection, resulting in a high number of indications. For example, in Cycle 1, this aspect was identified by only two stakeholders, but they chose it 12 times in total. One stakeholder identified it nine times and the other three times. Both these clients had been diagnosed with chronic illnesses, including chronic back pain and fibromyalgia respectively. Therefore it appears that pain or illness could have a negative effect on a client's experience of the group session.

Outsider perspective: During the study, I mentioned a few times in my observations that a stakeholder seemed uncomfortable, in pain or not feeling well. It was also mentioned by some stakeholders during the check in at the commencement of the group session that they didn't feel well or was in pain.

(e) I find it hard to focus and concentrate

Insider perspective: Ten reflections in Cycle 1 indicated that stakeholders found it hard to concentrate; Cycle 2 revealed that stakeholders found it hard to concentrate 21 times, and this was confirmed by three times in Cycle 3.

Outsider perspective: In my opinion, the reasons for poor concentration could be linked to the side-effects of their medication as mentioned before, or their emotional state as they are dealing with various issues in the group sessions. Individual therapy would also highlight trauma they might have experienced, where there is a strong focus on the problems they face. Alternatively, poor concentration may be linked to worries about something outside of the group.

(f) Breaks are too short

Impact on the research process: In Cycle 1, this aspect was indicated a few times by stakeholders in the qualitative data in the reflections. This aspect was not one of the options in the reflections used in Cycle 1 (Addendum G); however, was included as an extra option in the reflection in Cycles 2 and 3.

Insider perspective: It was evident that this aspect was seen as a negative, as 29 stakeholders had indicated this in their reflections in Cycle 2, and two in Cycle 3. It was also indicated in qualitative data from stakeholders that they felt that they needed more time for self-reflection after groups – thus a longer break. The following verbatim confirm this aspect:

"Sessions are too close together"
"There should be a 15 minute break between all sessions"

Outsider perspective: I also mentioned this aspect a few times in my reflections. I observed that stakeholders often came late after breaks, and even if there were no break on the program, stakeholders asked for a break or mentioned that the breaks were too short.

(g) I am physically uncomfortable (e.g. the chairs, air-conditioning etc.)

Impact on research process: This aspect was one of the options included as an extra option, as mentioned above (cf.4.2.3.2 f), in the stakeholder reflections after corroborated qualitative data from Cycle 1 indicated that this aspect had had a negative effect on stakeholders' experience of the group.

Insider perspective: This aspect was viewed as negative by stakeholders, as 24 stakeholders indicated this in Cycle 2 and three in Cycle 3. This was also confirmed in the qualitative data from stakeholders as the following verbatim data show:

"The chairs are uncomfortable"
"The chairs were hard"
"I sat uncomfortably"

A suggestion was also made for "more comfortable chairs".

Outsider perspective: I had also indicated in my observations that two stakeholders in different cycles complained that their feet didn't touch the floor, while some said that that the chairs were hard, and others who had back pain complained that the chairs were uncomfortable.

(h) I felt anxious, upset or depressed

Insider perspective: Stakeholders reported in their daily reflections (quantitative data) that their participation during the groups was influenced by depression, anxiety or being upset (Cycle 1: four; Cycle 2: 19; and Cycle 3: three). This was indicated especially within the first few days of the program.

Outsider perspective: I noted in my reflections that some of the stakeholders seemed anxious, especially at the beginning of cycles. A few clients throughout the cycles also remarked that they felt down (depressed). I found it interesting that one stakeholder in Cycle 1 acknowledged that they felt anxious, upset or depressed on the last day of the group sessions. I often noted that clients appeared to be scared of leaving the PC, a place that they considered a safe environment, to go back to face the same problems and circumstances that they had before. I observed that many found it sad to say goodbye after making new friends in the PC.

(i) I could not attend the group

Insider perspective: Stakeholders in all three cycles indicated that they could not attend all the sessions or missed part of the sessions due to various reasons. The group member attendance thus varied with every session and stakeholders experienced this negatively. Qualitative evidence from their daily reflections included the following"

"I missed a lot of the session due to an appointment with my psychologist"

Outsider perspective : According to my observations, the reasons for stakeholders not attending the groups included that they had appointments with their psychiatrist or psychologist during the time of the group; that stakeholders had to undergo medical tests

such as an EEG or CT scan at the PC or at other hospitals; that stakeholders were unwell due to side-effects from their medication or an illness such as the flu that kept them in bed; or that stakeholders were upset after sessions with their psychologist or a previous group session. According to my reflections, this seemed to bother the stakeholders as they often came to explain why they missed the session afterwards, or complained that they missed out and asked if I could see them individually to "catch up".

(j) I didn't sleep at all or I didn't sleep well last night

Insider perspective: The aspect of stakeholders not sleeping well or not sleeping at all was noted 16 times in total. This is also a familiar complaint from my previous experience and might be due to stakeholders' diagnosis; side-effects of medication as mentioned before' pain' the unfamiliar surroundings' worries or issues that the stakeholders struggle with; or roommates making a noise or snoring.

Outsider perspective: I remarked a few times on these indicators in the study as stakeholders complained a few times that they did not sleep well the previous night. This indicator however were indicated much less that the indicator of stakeholders sleeping well.

The aspects described above were based on Table 4.6 and included mostly quantitative data from an insider's perspective, and thus feedback and comments from the stakeholders. Due to a large amount of qualitative data obtained from an outsider's perspective, the data were analysed using multifaceted thematic analysis and will be portrayed in Figure 4.2 according to the different themes identified.

4.2.3.3 External indicators that had a negative impact on my life skill groups (outsider perspective)

My personal reflections and outsiders' perspective are presented under the following established headings:

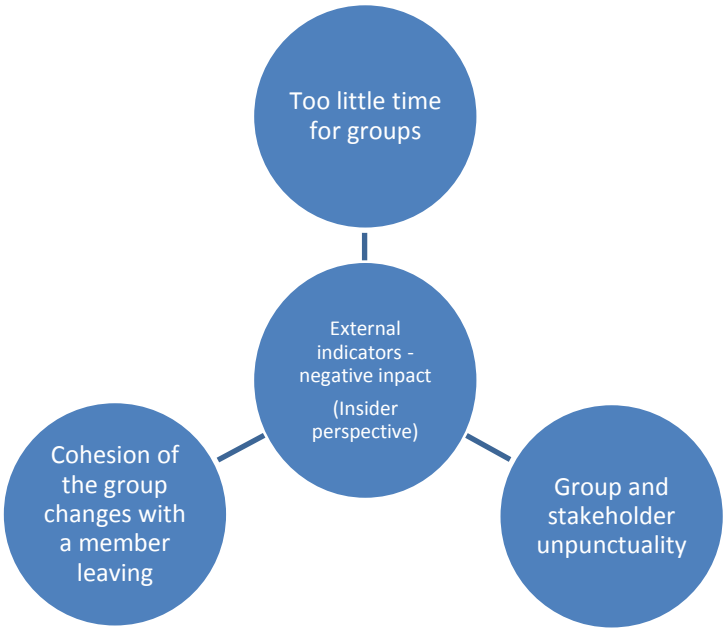


Figure 4.2 External indicators that had a negative impact on my life skill group sessions (Outsider perspective)

(a) Group and stakeholder unpunctuality (the group starting late)

I often recorded this factor in my reflections and observation of the groups. The groups frequently started five to ten minutes late due to various reasons. The first session in the morning tended to start slow/late as some clients still finished their breakfast, had their vital signs checked, and was administered their medication. There was also only one official tea break of 15 minutes in the mornings after session 2 (Addendum A). In between the first and second, and the third and fourth sessions, stakeholders took a quick unofficial smoke/tea break that most often influenced the starting time of the following groups, especially due to the fact that stakeholders who smoke had to go downstairs and outside to smoke, and this took time. This put added pressure on me to complete my session in time. Add-on impacts of starting late meant the value of the group was compromised as some information could not be provided or could only be mentioned without spending enough time on it, or stakeholders did not have time for self-reflection.

(b) The cohesion of the group changes when a group member leaves the group or when new members join the group

A change in group members appeared to have some influence on the cohesion and dynamics in the group. 'Interruption of groups' and 'appointments of group members with other team members' were identified as reasons for the variation in number of group attendees per session. This aspect possibly influenced the cohesion of the group, although it was not mentioned as such in the quantitative data obtained from insiders and only once in the qualitative data, where a stakeholder replied that two new group members, who only started to attend the group in week 2, brought tension to the group.

"New patients in the group bring tension"

The other remarks were focused more on the interruption of the group when a group member came back or left the group, as mentioned before.

(c) Too little time for groups

It has been mentioned before under "group and patient unpunctuality" that groups often didn't start on time and therefore the time to complete the group session was less than planned for. I noted a few times in my observations that one aspect of the group session had to be rushed due to time constraints; this was more prominent in Cycle 1. I also noted during Cycle 1 and 2 of the study that some presenters arrived late for their group sessions, causing them to exceed their allocated time slot, or others merely exceeding their allocated time without arriving late, causing my sessions to start late. It also happened that stakeholders took a short break after sessions where there was no allocated break. I came to the conclusion that some team members/stakeholders appeared not to respect the life skills group time slot, or that team members had too little time to fulfil their therapeutic obligations and therefore used any time available to them.

In my opinion, there are different ways to address this factor. The first option is for this factor to be addressed by the psycho-social group program presenters by altering the timeslots of the program or to address the issue of presenters exceeding their time limit with these presenters. The other option is to determine whether the goals of the session were not too many for that specific session.

Impact on the research process: As a program change could not be implemented during the study, I looked at my goals for Cycle 2 and also tried to manage my time better and motivate stakeholders to be on time. I felt that in Cycle 2 the time factor was addressed to some extent, but due to the fact that the group was very large, discussions and logistic matters took longer and also played a role. In Cycle 3 the time factor was not as much of a problem.

Another factor that I considered was that in Cycle 1 it took some time for stakeholders to complete their reflections at the end of the session. The reflections were seen as separate from the group session and had to be completed after the closure of the group. I therefore decided that the reflections in Cycles 2 and 3 should be incorporated in the closure of the group, thus as part of the group session. More time was now given for the completion, but it saved time as it was now being incorporated in the closure of the session.

Aspects which had had a negative influence on stakeholders' experience of the life skill groups have been discussed and will now be followed by the positive aspects that influenced the stakeholders' experience of the group.

4.2.3.4 External indicators that had a positive influence on the stakeholders' experience of the group

Table 4.7 lists the aspects that were indicated by stakeholders (insider perspective) in the quantitative data that had a positive influence on their experience of the group. It indicates the different indicators in all the cycles respectively as well as the total of all three cycles.

Table 4.7: External indicators that had a positive influence on the stakeholders' experience of the life skill groups.

Positive aspects				
	Cycle 1 Total number of times aspect was mentioned (73 questionnaires)	**Cycle 2 Total number of times aspect was mentioned (140 questionnaires)**	**Cycle 3 Total number of times aspect was mentioned (7 questionnaires)**	**Total of all three cycles (220 reflections)**
My mood is better today.	64	102	7	173
I feel motivated ("committed") to participate in the groups.	64	80	5	149
I slept well last night.	52	95	5	152
I focused and concentrated well today.	40	78	3	121
I am not experiencing any side-effects, my medication works well.	39	55	3	97
My psychical condition.	25	36	2	63
The time slot of the group. The time of day.	16	30	1	47
The fixed program, causing occupational therapy groups to not always follow on one another.	13	21	2	36
Other	11	3	1	15

The table above will be described from the aspect which had the most indications to the least indications (total indications). It is, however, evident that the internal indicators that had a positive influence on stakeholders' experience were indicated more and seemed to be more "significant" than some of the external indicators. Only the first five indicators will therefore be discussed.

(a) My mood is better today

Insider perspective: This aspect was indicated most often in the daily stakeholder reflections over the three cycles.

Outsider perspective: Already in the first group session in Cycle 1, stakeholders identified that their mood had improved. They also remarked in the group that they felt relieved to be there, and to know that they will receive help. Thus, the fact that stakeholders had hope may have positively influenced their mood. As mentioned before, the stakeholders received individual as well as group therapy which might have been beneficial in order to deal with trauma and problems in their lives. Stakeholders were also treated by psychiatrists, which often meant that they will receive medication to treat the specific disorder. Taking all the above treatment into account, it is feasible that stakeholders'

mood could possibly improve during the time that they were admitted and participated in groups.

(b) I slept well last night

Insider perspective: Stakeholders indicated 152 times that they slept well in comparison to the aspect of stakeholders 'not sleeping well' or 'not sleeping at all' which were noted 16 times (cf. 4.2.3.2 j) in the discussion of negative aspects (seven of which was identified by one stakeholder alone).

Outsider perspective: Many of the stakeholders reported that the reason that they slept well was because of sleeping tablets prescribed by their psychiatrist. Stakeholders remarked that it was very encouraging to be able to sleep well as many of them didn't sleep well before being admitted to the PC.

(c) I feel motivated ("committed") to participate in the groups

Insider perspective: Already in the first group in Cycle 1, stakeholders identified that their mood had improved. Especially Cycle 3 had a high indication with five out of seven, compared to 64 out of 73 in Cycle 1, and 80 out of 140 in Cycle 2. This aspect was ranked as the third highest indication that had a positive influence.

Outsider perspective: I noted that stakeholders remarked in the group that they felt relieved to be here, and to know that they would receive help. Some stakeholders also reported that they were not on any medication yet. It appears that hope was possibly instilled, which might have influenced the fact that stakeholders reported to be motivated to participate in the groups.

(d) I focus and concentrate well today

Insider perspective: In Cycle 1, 40 stakeholders indicated that they could focus and concentrate well, in addition to 78 stakeholders in Cycle 2 who indicated this aspect, and three indications in Cycle 3. This is positive that stakeholders reported to be able to concentrate in spite of the fact that they might have side-effects due to their medication as mentioned before, their emotional state as they are dealing with different issues in the

groups and individual therapy, or that they might be worried about something outside of the group.

Outside perspective: I mentioned a few times in my process notes that certain stakeholders seemed to be more focused than before. It was also mentioned a few times by stakeholders during the "check in" in the first occupational therapy life skill group of the day.

(e) I do not have any side effects – my medication works well

Insider perspective: It is unusual for stakeholders to indicate that they aren't experiencing side-effects, as this was one of the negative aspects indicated most often (42 times) under negative aspects discussed before. In contrast in Cycle 1 stakeholders indicated this aspect 39 times, in Cycle 2 it was indicated 55 times, and three times in Cycle 3.

4.2.4 Internal indicators

A greater understanding of the **external indicators** that had an influence on the experience of stakeholders was obtained and previously described. One of the first questions I asked as I reflected on my own practice at the beginning of the study was whether I had attained "best practice" with the facilitation of my life skill group sessions. In the following part of the chapter, the **internal indicators** (as specified by stakeholders) that had a **positive** influence towards their experience of the life skill group sessions will be described and will later be followed by internal indicators that had a negative influence on stakeholders' experience of the group. In this study **internal indicators (positive and negative factors)** refer to factors directly associated with the group process I am involved in, e.g. my facilitation of the overall group process, facilitation of the group sessions, and topics addressed in my life skill groups.

4.2.4.1 Internal indicators that had a <u>positive influence</u> on the stakeholders' experience of the life skill group (based on reflections)

Table 4.8 displays the indicators that had a positive influence on the stakeholders' experience of the group. It shows the number of times the aspect was indicated in

the specific cycle, as well as the total number of times over the three cycles. The data were obtained from the daily reflections completed by stakeholders (quantitative data). As noted before, 72 reflections were completed in Cycle 1, 140 reflections were completed in Cycle 2, and seven reflections in Cycle 3. The number of aspects indicated is thus the number of indications of that specific aspect within the specific cycle.

Table 4.8: Internal indicators that had a positive influence on stakeholders' experience of the group

Positive aspects	Cycle 1 (73 reflections)	Cycle 2 (140 reflections)	Cycle 3 (7 reflections)	Total (220 reflections)
	Total number of times aspect was indicated	Total number of times aspect was indicated	Total number of times aspect was indicated	Total number of times aspect was indicated over the three cycles
I can relate to the presenter.	70	115	7	192
I feel comfortable within the group setup.	68	103	4	175
I get to know myself better.	67	113	6	186
I received useful information.	65	122	7	194
I feel safe in the group; I feel I belong.	64	81	4	149
I realise that other people also experience difficulties in life.	62	98	6	166
I could identify with examples being used in the group.	56	83	7	146
I learned something from another group member.	56	77	1	134
I can say how I feel in the group and feel relieved afterwards.	55	65	5	125
I can socialise with other group members and do not feel alone.	54	78	2	134
I could identify with one of the other members of the group.	53	80	5	138
I meant something to someone else in the group.	37	39	4	80

Insider perspective: Table 4.8 shows that the aspects that were indicated most often in Cycle 1 were "I can relate to the presenter," followed by "I feel comfortable within the group" and "I get to know myself better." In comparison, most aspects indicated in Cycle 2 were "I received useful information," "I can relate to the presenter" and "I get to know myself better." In Cycle 3, three of the aspects were indicated in all of the stakeholder reflections, including "I can relate to the presenter," "I received useful information" and "I could identify with examples being used in the group." All the aspects that were included in the reflections were indicated in

the table, but only the ten aspects that were indicated the most (total of all three cycles) will now be described from the highest to the lowest. The therapeutic factor as identified by Yalom (1995) is also included in the heading.

(a) I received useful information (imparting of information)

Insider perspective: This aspect was mentioned 65 times in Cycle 1, compared to 122 times in Cycle 2, and seven times in Cycle 3 in the quantitative part of the reflections. This was also confirmed in the qualitative data obtained from the reflections, as stakeholders often mentioned that they had learned things that were meaningful to them. For example:

> *"It is positive to have learned how to say no"*
> *"I realise what I can do to better manage my Type A personality"*
> *"I learned a lot and feel motivated to apply the techniques that I learned"*
> *"I have to plan my day better to avoid stress"*
> *"I learned how to handle conflict within my setting"*
> *"I learned how to manage my anxiety better"*

These quotes indicate that the stakeholders perceived that they received useful information.

Outsider perspective: I often mentioned in my observations and reflections that stakeholders remarked at the closure of the group session that it had "made sense" and that they could mostly identify what specifically in the session was useful or applicable to them.

(b) I can relate to the presenter

Insider perspective: As noted in the stakeholder reflections (quantitative data), this aspect was the most indicated aspect in Cycles 1 and 3 (in Cycle 3, two other aspects also had the same number of indications; in Cycle 2 this aspect had the second highest indication). According to the qualitative data obtained from the reflections, my presentation appears to have been experienced as positive and stakeholders seemed to have felt that they could relate to me:

"Questions are comfortable and not too personal"

"The session was perfect"

"She presents the class wonderfully and explains everything nicely"

"… the therapist is perfect"

"The therapist presented information in a relaxed and insightful way'"

"Information was presented to me in a compact way that I could understand and it was done with empathy"

"The therapist handles the sessions very well"

"E is brilliant, I would not change anything. She adapted for my needs and I appreciate it immensely. She should stay the way she is"

Quantitative as well as qualitative data appeared to indicate that my life skill group facilitation was experienced positively by the stakeholders.

(c) I get to know myself better (self-understanding)

Insider perspective: This aspect was indicated six out of seven times by stakeholders in Cycle 3, while stakeholders noted it 113 out of 140 times in Cycle 2, and 67 out of 73 times in Cycle 1. Stakeholders often mentioned in the reflections that they learned more about themselves:

"Identification of my own shortcomings"

"I learned a lot of things about myself that I didn't know existed"

"I discovered more about myself"

"I learned more about myself"

"I got to know/understand myself better"

"I realised I can accept myself after all these years"

"I realised that I can love myself"

Outsider perspective: This aspect was also noted in my own observations and reflections (qualitative data). I indicated a few times that stakeholders mentioned that they had learned more about themselves and had gotten to know themselves better.

(d) I feel comfortable within the group (cohesion)

Insider perspective: As mentioned, this aspect received the second most indications in Cycle 1 with 68 out of 73 indications. In Cycle 2 this aspect was indicated 103 out of 140 times, and in Cycle 3, four out of seven. This aspect received less acknowledgment in the first week (in both Cycle 1 and Cycle 2) than in the second. This aspect is supported by the following verbatim (qualitative data):

"I could be myself in the group"

Outsider perspective: According to my own reflections, most stakeholders seemed to feel comfortable in the groups. In the beginning of the cycles (first or second day) it seemed that stakeholders at first felt a bit ill at ease, but as the cycle progressed they became more comfortable, which shows that possibly the cohesion in the group has an effect on how comfortable stakeholders feel in the group.

(e) I realise that other people also experience difficulties in life (universality)

Insider perspective: In Cycle 1, 62 stakeholders noted this aspect, with 98 in Cycle 2 and six in Cycle 3. This data was again obtained from the quantitative part of the daily stakeholder reflections. In the qualitative data in reflections stakeholders mentioned that it was positive to realise that other group members also had hardships or had the same problem/situation as they had:

"We are all broken"
"Other people also struggle with their self-image"
"I am not alone; I am not the only one with anxiety disorder"
"My situation is not so much worse than the rest of the group"
"I realized that other people also have problems"

Outsider perspective: From my experience, this aspect contributes towards cohesion in the group and the start of members being "the group." This is often the case when group members start seeing themselves as part of a group and not merely as individuals. It seems that this aspect also played an important role towards cohesion in the various cycles in the study.

(f) I feel safe in the group; I feel I belong (cohesion)

Insider perspective: Cycle 1 had 64 out of 73 (87%) reflections indicated, while Cycle 2 seemed to have less stakeholders feeling safe as 81 out 140 reflections indicated this (57%). In Cycle 3, four out of seven (also 57%) reflections indicated this aspect. This is positive, as more than half of the reflections indicated that stakeholders felt safe in the group. This aspect was supported by the following verbatim:

"I was accepted in the group and no-one judged me"

Outsider perspective: It was important to me that stakeholders feel safe in the group. I therefore mentioned to stakeholders with the compilation of rules that it was important that they felt safe. They thus had the opportunity to formulate rules to help them feel safe in the group. These rules included, for example, confidentiality, respect for one another, and not judging one another. I reported a few times in my reflections and observations that stakeholders seemed to feel comfortable within the group. One stakeholder remarked that the group felt like family. Another stakeholder reported that the group would not be the same without him and that he knows he was "supposed to be in the group." According to my observations, stakeholder's at times shared very sensitive information with one another it seemed to me that they trusted one another.

(g) I could identify with examples being used in the group

Insider perspective: All seven reflections from Cycle 3 indicated (quantitative data) this aspect, compared to 56 and 83 indications in Cycles 1 and 2 respectively. The following verbatim data confirmed the quantitative findings:

"There are practical examples which I can associate with and it helps me to remember and practice it better"
"The therapist gave practical examples of situations and that was positive"

Outsider perspective: It seems that stakeholders could often relate to the examples I used in the group sessions. Questionnaire 1 (Addendum F) assisted me to be more client-centred as I then had some background information on reasons why stakeholders

had been admitted or symptoms they presented with, and I used this in combination with information I gained during the group sessions.

(h) I could identify with one of the other members of the group (universality)

Insider perspective: Table 4.8 states that this aspect was indicated 56 times in Cycle 1, compared to 83 times in Cycle 2 and seven times in Cycle 3. Qualitative data in the reflections confirming this include:

> *"I also heard other group members' input about themselves and that gave me perspective / I could identify with them"*
> *"Other people had the same problems as mine"*

Outsider perspective: According to my own observations and reflections, it was very valuable to stakeholders to find that someone else was in the same situation as they were, or had the same problems. This was often mentioned by stakeholders in the groups.

(i) I learned something from another group member (interpersonal learning)

Insider perspective: Stakeholders indicated this aspect in the quantitative data in reflections in especially Cycles 1 and 2. Cycle 1 had 56 out of 73 reflections; Cycle 2 had 77 out of 140 reflections; and Cycle 3 had only one indication out of seven. It seems evident that stakeholders learned from other group members as it was again mentioned in the qualitative data in the reflections:

> *"I learned things from other group members"*
> *"We learn from one another"*

Outsider perspective: I reported this aspect in my reflections only once. A stakeholder remarked that he had learned a lot from another group member – the other member was in the same situation at work as he was.

(j) I can socialise with other group members and do not feel alone (development of socialising techniques)

Insider perspective: Table 4.8 revealed that this aspect was indicated 54 times in Cycle 1; 78 times in Cycle 2; and twice in Cycle 3. It is interesting to note that this aspect was indicated more in week 2 of the cycles than in week 1. For example, in Cycle 1 between 83% and 100% of stakeholders in week 2 indicated feeling able to socialise with other group members, while it was between only 50% and 75% in week one. The following written feedback by collaborators in the qualitative data of reflections confirmed that this aspect is important to stakeholders:

> *"It is OK to talk about your feelings and I found it very positive"*
> *"I can share how I feel 'with the group"*
> *"The interaction in the group is enjoyable"*
> *"The interaction of people was positive"*
> *"Group members interacted spontaneously"*

Outsider perspective: According to my observations and reflections, stakeholders valued the socialisation and interaction in the group. They often mentioned this in the group and also verbalised that they had withdrawn from people over the last few months/weeks, and that it was positive to see that they can still interact with people or are able to interact with other people.

The previous data mainly described the quantitative data from stakeholder reflections (insider perspective) with some qualitative data supporting it. Some aspects were not addressed in the quantitative part of the reflections, but appeared in the qualitative data from stakeholder reflections. The following themes were thus identified with the coding and analysis of the qualitative data and are supported by my own observations and reflections (outsider perspective).

4.2.4.2 Internal indicators that had a positive influence on the stakeholders' experience of the life skill group (themes identified with coding and analysis)

(a) Therapeutic factors made the group more effective and the group was highly valued by the stakeholders

Insider perspective: Therapeutic factors seem to have been present in groups of all three cycles, as indicated by stakeholders in the quantitative and qualitative data obtained from reflections as described. These include: instillation of hope; universality; imparting information; development of socialisation techniques; interpersonal learning; and self-understanding.

Stakeholders also reported to have valued the following attributes in the group, which they expressed as follows:

Trust and acceptance: *"No-one judges in the group"; "There is trust in the group and we can be ourselves"; "I was accepted in the group and no-one judged me".*

Sharing: *"We share our problems with one another"; "To know that there are other people that can share my feelings"; "I could share with the group how I feel"; "Group members could share their feelings".*

Caring and support: *"Others also care about your problems"; "It is positive to know people in the group care for me"; "The group members support each other".*

Cooperation and teamwork: *"The cooperation in the group was positive"; "The attitude in the group is very positive"; "Everyone participated"; "Good teamwork in the group".*

All the above-mentioned aspects worked together to create cohesion in the group. It appears as though cohesion was present in the groups, especially in the second week of the cycles.

The following verbatim account confirms that the group was valuable to stakeholders:

> *"The group helped me a lot, because I am scared to talk to people and I learned that there are other people who are also like that"*
> *"I now feel that the group was the best thing for me, although I was scared to be in a group at the beginning"*

Outsider perspective: I observed the following therapeutic factors in the groups (qualitative data from observations and reflections): instillation of hope; universality; imparting information; altruism; development of socialisation techniques; interpersonal learning; group cohesiveness; catharsis; and self-understanding. These factors seemed to have a positive impact on the therapeutic process and the effectiveness of the group.

(b) The use of activities in the group made the group more effective

Insider perspective: Throughout the study the activities used seemed to have worked well, as stakeholders mentioned these activities in the reflections (qualitative data), referred back to it a few times, and explained things by means of the activities, for example:

> *"It was positive to be able to use pictures to express examples of your life"*
> *"The presentation, especially the activity to demonstrate anxiety, was positive"*
> *"The collage helped me to express my emotions and feelings – I realised what the real problem in my life is"*
> *"Using the animals helped me identify things that I can discuss with my psychologist"*
> *"I enjoyed the activity"*
> *"I want to have more balance in my life, e.g. lion and mouse"*
> *"I do not want to be the roaring lion anymore, but the dolphin"*
> *"I can use my collage in order to talk to my psychologist"*
> *"Use more pictures in the group"*

Outsider perspective: Activities used in the groups worked well, according to my reflections and observations. A view of the activities will now be given.

The carousel activity worked very well in all cycles and stakeholders seemed comfortable to talk to one another; there was good interaction and they seemed to enjoy the activity. This activity was used for stakeholders to become acquainted with one another as well as themselves. With most of the projection techniques – especially objects and animals – it seemed as though stakeholders opened up more and the level of trust in the group deepened. This was observed in all three cycles. Spontaneous interaction between stakeholders occurred and there was not much need for me to facilitate during the discussions. It seemed as though most stakeholders valued the process of making a collage with role-players in their lives, and it seemed as if they found the time to self-reflect to be positive. In Cycle 1 during the feedback and sharing part of the session, some of the stakeholders became very emotional; however, they supported each other and reacted very sensitively to everyone's stories. This led to a positive change in the cohesion of the group. It seemed as though the use of activities in the group sessions had built cohesion, deepened the level of trust in the group, and led stakeholders to self-understanding. Cycle 3 contained an additional reflection on the use of activities, and all stakeholders confirmed that they experienced the activities and worksheets positively, and as factors that added meaning to the group session.

(c) Hope was instilled in the stakeholders

Insider perspective: It was reported a few times in the qualitative data from stakeholder reflections that stakeholders had felt more positive and had some hope. Verbatim data that support this notion include:

> *"One can change, but it has to start with yourself"*
> *"I realise that things can change for the better, if I work at it"*

Outsider perspective: According to my observations and reflections, it appears as though hope was instilled in the stakeholders in all three cycles. This seemed more evident in the beginning of the group, as stakeholders reported feeling relieved that they were going to get help and had hope that they will be better after the two-week program. The instillation of hope was again more prevalent towards the end of the two-week program as stakeholders' moods seemed better and they reported feeling confident and had hope that they would cope better in the outside world and apply the skills they had learned and use the tools they had received after being discharged.

(d) The stakeholders' moods improved towards the end of the cycle

I observed in all the cycles that stakeholders seemed to feel scared to go home towards the end of the two-week program, yet they also said that they felt they now had more skills to cope in the outside world. The stakeholders stated that the psycho-social program at the PC had helped them significantly; most of the stakeholders described starting off in an emotionally very bad place in the first week, and that at the end they had more hope. Many stakeholders stated that their mood was much better. The aspect of stakeholder's improved moods was also evident in the quantitative results as described previously (cf. 4.2.3.4 a).

The following verbatim supports this:

"I am better"

The **internal indicators** (specified by stakeholders) that had a **negative** influence towards their experience of the life skill groups will now follow.

4.2.4.3 Internal indicators that had a <u>negative</u> influence on the stakeholders' experience of the life skill group

(a) My stress or emotional state as presenter

Outsider perspective: I was stressed about the study on the first day of Cycle 1 of the research study, as I did not know what to expect and how clients would react towards the study. I felt guilty to ask clients to participate in a study that would take some of their time – especially if they were not feeling well. In my view, this influenced my presentation of the group negatively, as I was not as spontaneous in my presentation of the sessions, and I presented the sessions, rather than facilitating them. I thus gave stakeholders less "freedom" to talk about their experiences and needs. My emotional state therefore had a negative impact on my client-centred practice in my view on the first day of the cycle. Later on in the week I felt very comfortable and confident with the study and with presenting the life skill group sessions, and I didn't feel that my facilitation was affected by stress.

On the Tuesday of the second week of Cycle 1, I was upset by an incident within in the practice before my group sessions started, and I felt that it influenced my facilitation of the group. In Cycle 2 the size of the group had me worried and I felt anxious, but I do not think this influenced my facilitation of the group. In Cycle 3 I did not feel stressed or anxious – I felt comfortable – but due to deadlines for data to be sent to the Department of Biostatistics before the December holidays I didn't sleep as well as I usually did, which caused me to feel tired and not having much energy – in the second week it felt as if I had to work harder than normal in the group sessions. Although it felt as if I had to work harder, I do not think it influenced the group negatively.

Insider perspective: The above-mentioned feelings that I had about my facilitation of the group did not show in any qualitative or quantitative data obtained from stakeholders. According to data from stakeholders, it seemed as though stakeholders still became aware of aspects regarding their self-image; they gained knowledge and there was good cohesion in the group; and stakeholders experienced the facilitation as positive.

(b) Too little time for reflections

Outsider perspective: In Cycle 1 my observations and reflections mentioned a few times that there had not been enough time to fill out reflections appropriately. This might be due to groups starting late as discussed before, or that the closure of the group takes too long.

Impact on the research process: The reflections were initially seen as separate from the group session and thus always had to be completed after the closure of the group session. In Cycle 2 and later Cycle 3, I incorporated the filling out of the reflection as part of the closure of the group. This saved some time and gave stakeholders enough time to complete the reflection and give feedback on what they have learned or realised in the group as part of the closure of the group. This change in Cycles 2 and 3 worked very well; however, sufficient time to fill out the reflection was more of a challenge when the group session started late or if the group attending was large.

(c) Suggestions towards the group sessions

The following suggestions were made regarding the groups. Each suggestion was made by only one stakeholder and will be described accordingly.

(i) *Insider perspective:* Suggestions were made by one stakeholder to focus more on stakeholders' individual problems, which is usually the focus of the therapist.

Outsider perspective: To focus on every stakeholder's individual problem is in practice a challenge due to the fact that there is limited time, and also because some stakeholders would then talk about their own problems for the duration of the session. The therapist therefore has to facilitate the group in order to include all stakeholders and help them to focus on themselves, gain insight into their behaviour, and make the information applicable to themselves (internalisation). I feel that I achieved this in the groups.

(ii) *Insider perspective:* There was a suggestion for more real-life scenarios.

Outsider perspective: In the specific session in Cycle 1 it was done my means of examples that I used. According to the quantitative data (cf.4.2.3.4), six of the eight stakeholders could identify with the examples used in that session; it was also only the second day of the program, which meant that stakeholders might not be as open about their own lives yet. However, I kept this in mind for future group sessions.

(iii) *Insider perspective:* A suggestion was made for more ongoing interactions. ("*Group members must almost never sit still for long.")*

Outsider perspective: After clarifying this with the stakeholder, I established that he had meant that he wanted more movement, as they sit a lot throughout the day; he said it was meant more in general for all the groups. In this session there was some moving around, but it will also be kept in mind for future groups or cycles. However, it was not mentioned in the quantitative data as a negative aspect towards stakeholder's experience of the group in any cycle.

(iv) *Insider perspective:* Another suggestion that was made a few times was for more time for self-reflection.

Outsider perspective: A discussion with the stakeholder who made the suggestion clarified that by "time for self-reflection" he meant more time in between

groups/breaks, as a large amount of information is delivered during sessions and there is very little time to process it. It was, however, again not mentioned as a negative aspect in the quantitative data or qualitative data from reflections – only that more breaks were needed.

(v) *Insider perspective:* A suggestion was made by a stakeholder that more probing questions should be asked ("*more probing questions*").

Outsider perspective: In my experience, this could cause some stakeholders to withdraw. I already facilitate interaction and often stakeholders are challenged on their behaviour, and social skills and self-exposing questions are often asked. I think probing questions should be left to the OT to use within their clinical judgement and reasoning and in the right time within the group process.

4.2.5 Effect of the life skills program on stakeholders (their experience in terms of knowledge gained, enablement, client-centredness and satisfaction)

The final questionnaire (Addendum H), completed at the end of Cycle 1 (by five collaborators) and Cycle 2 (by 13 collaborators), assisted in providing an insider's perspective on what stakeholders indicated they gained from attending the life skills program. As sufficient data were gained in Cycles 1 and 2, this questionnaire was not used in Cycle 3. This questionnaire focused on different topics addressed in the occupational therapy life skill groups.

When considering the knowledge gained, the following questions were asked to establish in which area stakeholders felt that they gained the most knowledge and therefore were most enabled. This is summarised in Table 4.3.

Table 4.9: Knowledge gained

	Cycle 1			Cycle 2		
	Definitely	**Some**	**None**	**Definitely**	**Some**	**None**
Have you gained knowledge on stress?	5	0	0	13	0	0
Do you understand your own stress better? (Stressors, symptoms, coping strategies.)	4	1	0	10	3	0
Do you feel motivated to apply stress management techniques in future?	4	1	0	12	1	0
Have you gained knowledge on anxiety?	0	3	0	13		0
Do you understand your own anxiety better?	2	1	0	11	2	0
Are you willing to manage your anxiety differently in future according to the guidelines discussed in the group?	2	0	0	13	0	0
Do you understand what self-image is and how it influences your behaviour?	5	0	0	13	0	0
Do you now have knowledge on your strong and weak points?	4	1	0	12	1	0
Do you now have a different/new view about yourself?	4	1	0	12	1	0
Did you get to know yourself better?	5	0	0	13	0	0
Are you now more aware of your own needs and expectations?	4	1	0	11	2	0
Do you feel that you have been equipped (have the necessary knowledge) to communicate better in the future?	3	2	0	11	2	0
Are you aware of how you usually communicate and the communication mistakes you make?	4	1	0	8	5	0
Are you motivated to experiment with things you learned about communication in future, to find ways that work for you?	4	1	0	10	3	0
Do you know what assertiveness is?	3	1	0	10	3	0
Are you aware of how you normally behave towards other people (passive, aggressive)?	1	3	0	10	3	0
Do you think you will be more assertive in future? Are you willing to apply the assertiveness techniques that you have learned?	3	1	0	11	2	0
Are you aware of how you normally behave in a conflict situation?	4	1	0	12	1	0
Do you now know what to do to have a better outcome for your conflict situation?	3	2	0	13	0	0
Are you going to try to manage your conflict differently in the future?	5	0	0	12	1	0

According to Table 4.9 it seems as if stakeholders' self-understanding improved, as well as their knowledge on the topics facilitated, and it also seems that stakeholders felt enabled to apply some of the techniques in future. Table 4.9 will be discussed below from the aspects that the most knowledge were gained on, to the least knowledge gainded as indicated by stakeholders.

Insider perspective: Table 4.9 shows that the most knowledge gained towards enablement indicated by stakeholders in the final questionnaire (quantitative data) seems to be associated with knowledge on stress; how their self-image impacted on their behaviour; and that they understood themselves better. These aspects seem to be confirmed in the qualitative data obtained from the daily reflections of stakeholders. The knowledge on stress is supported by the following verbatim data:

"I became aware of my stress symptoms and realised that I have a lot of them"
"I now realise how my body reacts to stress"
"Chronic stress can lead to depression"
"I understand what my stressors are"

Stakeholders also showed insight into (became aware of) the impact of their self-image on their own behaviour in both Cycles 1 and 2. The following verbatim verify this notion:

"I withdraw from people due to my poor self-image"
"My inside picture (self-image) influences my behaviour'
"I realise because of my own hurt I sometimes hurt other people with my words and actions"

Stakeholders indicated the following verbatim supporting that they understood themselves better:

"I got to know/understand myself better"

This type of comment was very common in the qualitative data obtained from stakeholder reflections.

The second 'most knowledge gained' indicates that stakeholders were motivated to manage stress differently in future and this is confirmed by the following verbatim:

"I have to plan my day better to avoid stress"
"I should not try to do too much work on one day"

"I can state my boundaries and plan my day better to overcome my stress problem"
" There always has to be balance in your life"
"I see things in a different perspective and can try to handle things differently or better to make my stress less"

According to table 4.9 the third 'most knowledge gained' included that stakeholders felt motivated to apply mastered stress management techniques; they understood how to approach conflict situations; previous conflict management was identified; they had insight into personal strengths and weaknesses; and confirmed that they saw themselves differently (more positively). All these aspects were confirmed by stakeholders in the qualitative data of the daily reflections.

Motivated to apply stress management techniques:

"I have to make more time to relax"
"I realise good planning is very important and can make your stress less"

Know how to approach conflict situations:

"I should cool off before I react"
"I learned how to handle conflict within my setting"
"I learned a lot and feel motivated to apply the techniques that I learned"

Previous conflict management identified:

" I talk before I think and do not listen"
"I make assumptions and react on what I 'think' the person is going to say"
"I talk before I think"
"I realised I do not talk when something bothers me and then burst"

Insight into personal strength and weaknesses:

"I can see myself now as a whole (put things in perspective) – not only one part"

"I have a lot of positive attributes to work with"

"I identified my own shortcomings"

Saw themselves differently (more positively):

"I am not as bad/useless as I thought"

"I realise I also have good attributes"

"Every person is unique – God made us that way"

"I look at myself with new eyes and can handle my problems better now"

The fourth 'most knowledge gained' comprised of stakeholders who were motivated to manage conflict more effectively in future; this is confirmed by qualitative data from daily reflections by stakeholders and includes the following:

"I must learn to say no"

"I should cool off before I react"

"I learned a lot and feel motivated to apply the techniques that I learned"

The fifth 'most knowledge gained' comprised of stakeholders who felt equipped to deal with their own anxiety in more effective way; stakeholders who gained understanding in their own needs and expectations. These are again supported by qualitative data from daily reflections, noting the following verbatim:

"I have to replace negative thoughts/views with more balanced/realistic ones"

"There are ways to manage your anxiety better"

"I learned how to manage my anxiety"

"It would make my anxiety less if I do not postpone, delay the things I have to do"

"I must spoil myself sometimes"

"I have to think about myself more"

"I realise that I let people use me and I should not let them (it makes me unhappy)"

"I also have a right in life"

The sixth 'most knowledge gained' included the following aspects and are supported by qualitative data from reflections:

Stakeholders understood their own stress better:

"I became aware of my stress symptoms and realise I have a lot of them"

"I now realise how my body reacts to stress; I understand what my stressors are"

"I realise I have stress that I didn't know of; I realise stress influences me negatively"

"I realise that my experience of my senses can influence my stress"

"Stress makes me more sensitive to sensory input'"

Stakeholders felt more equipped to communicate more effectively:

"I can talk to the group"

They were also willing to trial new ways to communicate:

"I should share more with people I trust"

"I learned a lot and feel motivated to apply the techniques that I have learned"

Stakeholders felt enabled to implement assertiveness techniques:

"I may say no without explaining myself"

"I have to face my problems and not allow people to walk over me"

"I have to have boundaries"

"I can be more assertive"

"It is positive to have learned how to say no"

"It is positive that I can be assertive and more in control"

"I learned how to be more assertive"

The seventh 'most knowledge gained' included stakeholder knowledge gained about anxiety and assertiveness:

"There is a difference between anxiety, panic and fear"

"It is positive to have learned how to say no"

"Assertiveness is very important and it determines how people will treat you"

"It is positive to know it is okay to say no and to not always please everyone"

"It is positive that I can be assertive and more in control"

"I am a passive person/passive aggressive – and that influences my relationships negatively"

"My behaviour style is morning-evening type and it does NOT work for me as I have said in the group"

Awareness of communication skills:

"I talk before I think and do not listen"

"I make assumptions and react on what I 'think' the person is going to say"

"I talk before I think"

Insight into assertive behaviour:

> *"I realize I am a chameleon, changing colour to please everyone"*
> *"I realise I am a very soft-hearted person (passive) and let people abuse me"*
> *"I realise I have to show how I feel and be more lenient towards others"*
> *"I have to listen more to others and not get angry so easily"*

Insider perspective: In my own observations and reflections I often noted that it seemed as though stakeholders had gained self-understanding, showed insight into their own behaviour, and gained knowledge on different topics. Especially towards the end of the cycles, stakeholders seemed to feel enabled as they commented that they are going to use the "tools" they received or that they were going to apply what they learned. Some have also mentioned that they knew it was not going to be easy, but that they were willing to try and felt they would be able to do it.

As client-centredness is seen as the optimum way of practice, the stakeholders (insider) perspective/view regarding this is of great value.

Table 4.10 is based on the Client-centred frame of reference and aimed at determining whether the stakeholders felt that the occupational therapy life skill groups were client-centred. It addressed all the key components of client-centred practice (cf. Figure 2.2) and also the satisfaction of the stakeholders regarding the occupational therapy service. This data were obtained from the last questionnaire completed by stakeholders.

Table 4.10: Stakeholders' perspective on client-centredness

		Cycle 1 (n=5)			Cycle 2 (n=13)		
Key concepts of client-centred practice addressed with the question	**Question**	**Yes**	**To some degree**	**No**	**Yes**	**To some degree**	**No**
Autonomy/ Choice	Did you have enough information with the commencement of the program to make the decision to attend occupational therapy groups?	4	1	-	10	1	2
Autonomy/ Choice	Do you feel that you made the choice yourself to join the occupational therapy groups?	5	-	-	11	2	-
Partnership and responsibility	Did it feel as though you were given the opportunity to take responsibility for yourself in the occupational therapy groups?	4	1	-	12	1	-
Partnership and responsibility	Was the occupational therapist in a role where she led you and facilitated the therapeutic process, rather than dictating what you have to do?	4	1	-	12	1	-
Enablement	Do you feel you had the opportunity to identify your own "life skill" goals?	5	-	-	13	-	-
Enablement	Have you reached your own "life skill" goals? If not possible in hospital, are you willing to try to achieve it at home?	5	-	-	12	1	-
Enablement	Did the occupational therapist lead you and enable you to reach your goals?	5	-	-	12	1	-
Contextual congruence	Do you think the occupational therapist understood your specific situation and roles you take on etc., and took it into account during groups?	4	1	-	13	-	-
Accessibility and flexibility	Were the occupational therapy groups accessible – easy to attend?	5	-	-	13	-	-
Respect for diversity	Have your needs been satisfied during the occupational therapy groups?	5	-	-	13	-	-
Respect for diversity	Did the occupational therapist in your experience respect your opinions, values and goals in the sessions?	5	-	-	12	1	-
Satisfaction	Is your attitude towards occupational therapy groups currently positive?	5	-	-	13	-	-
Satisfaction	Do you feel that you were satisfied with the service rendered by the occupational therapy groups?	5	-	-	12	1	-
Enablement	Do you feel that the occupational therapy groups contributed to enable you towards better quality of life?	5	-	-	13	-	-
Satisfaction	Do you think occupational therapy groups played a positive role in your healing?	5	-	-	13	-	-
Satisfaction	Will you encourage/recommend someone else to participate in occupational therapy life skill groups?	5	-	-	13	-	-

According to Table 4.10 it seems that most stakeholders felt that the occupational therapy life skill groups were client-centred and felt satisfied with the service rendered

- **Accessibility and flexibility**

Insider perspective: This concept was indicated by all stakeholders in the quantitative data from the last questionnaire, as seen in Table 4.10.

Outsider perspective: It seems evident that the occupational therapy life skill groups were easily accessible and easy to attend. The PC comprises various facilities in the same building, i.e. the bedrooms, consultation rooms and the group therapy rooms. This probably eases accessibility.

- **Respect for diversity**

Insider perspective: This concept was also indicated by all stakeholders (in the quantitative data from the questionnaire, Table 4.10) to have been present within the life skill groups. It seems as if stakeholders felt that I was being respectful in terms of their differences/diversity.

This is supported by the fact that one hearing-impaired stakeholder reported the following in the qualitative data from the reflections:

> *"E is brilliant. I do not want to change anything. She adapted for my needs and I appreciate it very much. She should stay who she is."*

- **Enablement**

Insider perspective: According to the questions relating to enablement in the last questionnaire, most stakeholders felt that they had gained knowledge and were enabled . This is also confirmed by the qualitative data in reflections indicating the following:

> *"I learned how to handle obstacles"*
> *"The fact that I have to be assertive is positive"*
> *"I now have skills to apply and I WANT to apply it"*
> *"I realise what I can do to better manage my Type A personality"*

Outsider perspective: In order to work towards enablement where the stakeholder can achieve what they want to, they first have to gain knowledge (awareness) regarding themselves and the topics facilitated. There are a few verbatim in the window above this paragraph that give

the impression that stakeholders were moving towards enablement or felt enabled to change their habits or behaviour, to entertain new ways of doing things or to apply techniques that they have learned as noted above. According to my observations and reflections, stakeholders seemed to have gained awareness (self-understanding) and knowledge toward enablement as they could, for example, identify their stress symptoms and stressors in their lives, showed insight into factors influencing their self-image, and reported that they have gained skills such as assertiveness techniques that they wanted to use outside the PC. It is, however, apparent that stakeholders felt more enabled in the second week of the program – this makes sense as the program in the first week focuses more on awareness, and knowledge towards enablement in the second week of the program.

- **Satisfaction**

Insider perspective: This aspect was indicated the same weight as enablement. In Cycle 1, 100% of the stakeholders replied that they were satisfied with the occupational therapy service rendered, that the occupational therapy groups played a positive role in their healing, and that they would encourage other people to also join occupational therapy groups. In Cycle 2 it was indicated twice that the stakeholders were satisfied in some degree; the rest of the indications all noted that the stakeholders were satisfied with the service.

Outsider perspective: The fact that satisfaction was indicated as often as it was shows that the stakeholders felt satisfied with the service rendered and felt that they were helped. This is confirmed in the fact that stakeholders also wanted other people to receive help. The following verbatim supports this:

"We must encourage more people to come for help"

- **Contextual congruence**

Insider perspective: All but one indication on the questionnaires in Cycles 1 and 2 showed that contextual congruence was attained. One indication was that it was attained in some degree.

Outsider perspective: As mentioned before, the first questionnaire was used to help me attain contextual congruence.

- **Partnership and responsibility**

Insider perspective: The data from the last stakeholders' questionnaire show that on the question "Did you feel as though you were given the opportunity to take responsibility for yourself in the occupational therapy groups?" all but two stakeholders felt that they had. The other two stakeholders answered that they were given the opportunity to take responsibility "to some degree". On the question "Was the occupational therapist in a role where she led you and facilitated the therapeutic process, rather than dictating what you have to do?" the outcome was the same as for the first question. It seems, then, that most stakeholders felt that this concept of client-centred practice was attained.

- **Autonomy and choice**

Insider perspective: According to the quantitative data from the last questionnaire, this was the concept that was indicated to be the least attained of all the key concepts of client-centred practice. One stakeholder in Cycle 1 and one stakeholder in Cycle 2 indicated that they only had enough information "to some degree" with the commencement of the program to make the decision to attend occupational therapy groups. Two stakeholders in Cycle 2 also indicated that they didn't have enough information to make a decision. On the question of whether the stakeholder had made the choice to join the occupational therapy groups themselves, one stakeholder in Cycle 1 and one in Cycle 2 indicated that the choice had been made by themselves "to some degree." No qualitative data regarding autonomy and choice were obtained from stakeholders.

4.2.6 The research process

In the evaluation stage (stage 4) of Cycle 1 my critical friend and I made some observations regarding the research process. The problems were identified and addressed in the following ways in Cycle 2 and Cycle 3 (some of the problems have already been discussed earlier in the chapter).

(a) Problem: I found it difficult to write up my reflections and observations on the group session and it ended up as pages and pages of often unimportant information. I didn't have any guidelines on how to do this.

Solution: After consultation with my critical friend, it was decided to use Gibbs' Reflective cycle (Gibbs 1988) to document my data.

This included:

- Description (What happened?)
- Feelings (What were you thinking and feeling?)
- Evaluation (What was good and bad about the experience?)
- Description (What sense can you make of the situation?)
- Conclusion
- Action plan
- This cycle continues

(b) *Problem:* I found it hard to remember everything that happened in the group session, especially if the groups follow immediately after each other.

Solution: I tried as far as possible to write reflections directly after the group session or to make short notes.

(c) *Problem:* As reflections and questionnaires were not always checked directly after the group session, some uncertainties regarding information on these were not clarified. I also missed some information as I only realised after the cycle, when I had an in-depth look, that there was information that had the potential to enrich the study.

Solution: Look at reflections and questionnaires after they have been received back from the stakeholders (daily) and do member checking when:

- There is uncertainty about what is written in the questionnaire due to the stakeholder's handwriting.
- There is a remark which needs clarification.
- There is an opportunity to enrich the study.

General points to keep in mind:

- Start on time as far as possible.
- Give time for self-reflection when appropriate.

4.3 SUMMARY

This chapter reported the vast amount of findings generated by the process of action research. In general, these findings shed light on the indicators impacting on my two week life skill program, with pointers towards upholding client-centredness.

Findings highlighted the fact that several indicators influence stakeholders' experience of groups. These indicators were described as internal and external indicators, as well as positive and negative. (These factors are not all related to my facilitation of groups and therefore not all within my control).

Stakeholders' experience of Yalom's therapeutic factors; and the tendency to value being part of a group above all else, ascended all other findings. They reported to be satisfied with the occupational therapy service, and most stakeholders felt that they had gained knowledge and were enabled with regards to applying newly learned skills at home.

In the following chapter, these findings will be discussed and argued, also against the background of literature.

CHAPTER 5

DISCUSSION

"As you navigate through the rest of your life, be open to collaboration.
Other people and other people's ideas are often better than your own.
Find a group of people who challenge and inspire you,
spend a lot of time with them, and it will change your life."
(Poehler: 2011)

In my AR journey of discovery this advice became a reality to me, as I was privileged to have found three groups of people to spend time with. They challenged and inspired me. I was open to collaboration - and it changed my life as a therapist.

This is how my journey began…

5.1 Introduction

Chapter 4 comprised of the findings of the study (presentation of data obtained throughout the study). In this chapter these findings will be integrated and discussed.

After an introduction to the stakeholders (5.2), the discussion of findings will be guided by the key-concepts of client-centred practice (5.3), as client-centred practice was viewed as the occupational therapy theoretical framework in support of the ethos of this study and also as it is seen as the optimum way to provide an occupational therapy service (cf. 2.4.1). Along with discussing the findings based on the concepts of client-centred practice, the chapter will take on the form of the journey of a client admitted to the PC for the first time.

5.2 The stakeholders (cf. 4.2.2)

Stakeholders who participated in Cycles 1, 2 and 3, will now be introduced in terms of age, level of education and vocation, address, gender; and reasons for admission to the PC.

5.2.1 Age

The ages of stakeholders ranged from 20-65. That puts the groups' median ages at 37 in Cycle 1, 39 in Cycle 2 and 39 in Cycle 3. If one takes into account that most clients are admitted for issues around mental health, it points to the need to consult prevalence rates associated with specific age brackets.

The South African Stress and Health (SASH) Study (Herman, Stein, Seedat, Heeringa, Moomal, and Williams 2009:340-341) indicated that all disorders were more prevalent in an age bracket of 35-49 year old South Africans, as compared to people older than 65 years. Kessler, Amminger, Aguilar-Gaxiola, Alonso, Lee, and Ustun (2007:359-364) describe the age of onset for mood disorders as 25-45 years, with 30 years regarded as the life time age onset. The age onset of anxiety disorders is similar, and ranging from 25-53 years (Kessler *et al.* 2007). The age of stakeholders in this study, therefore concurs with the norms reported in literature. From my experience the ages of clients varied a lot, but seemed to compare well with the above-mentioned age bracket of 35-49 years of age.

5.2.2 Level of education and vocation/occupation

The level of education and occupations in this group varied considerably. Only 40% of stakeholders had a tertiary education, with the education of other stakeholders tending to include not completing school, to completing school.

This is consistent with literature, where Dalgard, Mykletun, Rognerud, Johansen and Zahl (2007:7-20) have pointed out an increased rate of psychological distress and consequent mental health problems for Norwegian people with low level of education (they indicate 7–10 years as low level, 11-14 years as moderate and 15 years as high). In this study, people not completing school, may be compared to the sample in the study of Dalgard *et al. (*2007).

With regards to vocation, stakeholders reported a wide range of occupations from being students and pensioners, to teachers, policemen and medical professionals. Eight stakeholders reported to be homemakers, and this turned out to be the best presented vocation of all. This variety of vocations (and inherently – a variety of backgrounds and daily contexts), had to be taken into account by myself in terms of my presentation of groups (cf.1.1). Finlay (1993:100-101) supports this when she states that the level of functioning of group members should be considered very well, as it will impact the "type, choice and level of group activity offered". The

fact that homemakers were the best presented vocation for instance influenced the examples I used in the groups, as I had to make it relevant to a person not within a setting of formal employment. I also chose my type of group activity, keeping the level of functioning of stakeholders in mind.

5.2.3 Address

Stakeholders resided in various provinces, with the most stakeholders from the Free State, Northern Cape and North West province, as supported by the hospital statistics, which indicate that predominantly the clients admitted to the PC are from these three provinces (Hospital statistics 2013). The PC is one of not so many private mental health facilities which serve people from these regions, which probably explains the fact that most PC clients reside in the Free State, Northern Cape and North West. The SASH study (Herman *et al.* 2009:341) confirms a high prevalence of mental health disorders in the Free State.

5.2.4 Gender

Stakeholders included more women than men, in all the cycles. The American Psychiatric Association (2013:167) describes Major Depressive Disorder to be more prevalent in women than men. The SASH study (Herman *et al.* 2009:341) found that being female, increased the severity of disorders, as well as the prevalence of mood and anxiety disorders; with substance abuse disorders being more prevalent amongst men. I also experienced that the female ratio in groups where more woman than men and this correlates with literature.

5.2.5 Reasons for admittance

Stakeholders indicated depressed mood as the most prominent reason for admittance, with anxiety as the second and tension in relationships the third reasons. Although a depressed mood is a main symptom of depressive disorders; and anxiety of anxiety disorders (American Psychiatric Association 2013: 155-188 and 189-233), data does not contain formal diagnosis.

The third reason, tension in relationships, may be explained by literature that describes the detrimental influence of mental illness on functioning in social spheres, which increases the level of tension in relationships (American Psychiatric Association 2013:155-188, 189-233; Cara & MacRae 2005:170-173, 199; Stoffel & Tomlinson 2011:303-304).

Stressful life events such as stress at work, someone close to a stakeholder that passed away, a traumatic experience, divorce or to be a carer for another person, is all consistent with literature as environmental stressors that might cause or aggravate mental illness (American Psychiatric Association 2013:155-188, 189-233, Cara & MacRae 2005:170-173).

According to the American Psychiatric Association (2013:166-167) people with pain and chronic or disabling medical conditions, have an increased risk for major depressive episodes. It also states that on the other hand people with depressive disorders are more prone to physical illness, and show a higher prevalence in problems regarding their physical, social and role functioning. Cara and MacRae (2005:431) support this notion and explain that often people with chronic pain have fluctuating emotions, ranging between hope, fear and disappointment often leading towards helplessness and hopelessness after a period of time. This often has a negative impact on meaningful occupations in the person's life which in effect cause the person to focus more on his/her physical symptoms, causing increased pain and symptoms of depressed mood and insomnia. It is thus evident from literature that there is an association between chronic pain or a physical illness and mental ill health.

5.3 Discussion of findings against the background of client-centredness

Client-centred practice acknowledges the client as an active participant in therapy, rather than a passive party on the receiving end of therapy (Boyt Schell *et al.* 2014a:1230). As an active party, the client's "knowledge and experience, strengths, capacity for choice and overall autonomy" (Boyt Schell *et al.* 2014a:1230) is emphasized by this approach, rather than only the supposed knowledge and expertise of the therapist. As mentioned, the key concepts of client-centred care (cf. Figure 2.2) include: **autonomy/choice, partnership and responsibility, enablement, contextual congruence, accessibility and flexibility** (Law *et al.* 1995:250-258; Parker 2011:140-141).

As mentioned before, the concepts of client-centredness will be the framework for this chapter; and applied to our client for this chapter - Mister HM. He was admitted to the PC on Sunday, and as many other clients, I met him for the first time Monday morning during my first group session for the next cycle of two weeks. The challengers and promotors of each concept[1], as applied to Mister HM as our client, as well as implications for future practice, will be described. This will be done with mention to data, literature and my own experience.

[1] Autonomy/choice, partnership and responsibility, enablement, contextual congruence, accessibility and flexibility (Parker 2011:140-141).

5.3.1 Autonomy and choice

Autonomy and choice, as key-concepts of client-centred practice, allow clients to be the experts of their own lives and to have the opportunity to make choices regarding intervention (Parker 2011:140-141). In order to allow the client to speak up regarding intervention, based on his own experience and knowledge (Townsend, Stanton, Law, Polatajko & Baptiste 2002:80), a therapist needs to provide adequate information allowing for informed decision making (Sumsion 2006:44).

5.3.1.1 The challenges regarding autonomy and choice

After admission to the PC, clients (such as Mr HM) have the opportunity to attend a two week psycho-social group therapy program (cf. Table 2.2). The topics in the structured programme are predetermined, and clients do not have a say in which topics are addressed in the groups. Although they are, in theory, allowed to choose which group sessions they will attend, they are very strongly advised and motivated by all staff to attend as many groups as possible. Mr HM may therefore feel he has no choice regarding the attendance of groups.

Quantitative data from the last questionnaire indicated that stakeholders felt this concept (autonomy and choice) to be the least attained of all the key concepts of client-centred practice (cf. Table 4.10 and Figure 4.4).

5.3.1.2 The promotion of autonomy and choice

Even though clients are not left with much choice about the topics and attendance of groups, they receive information regarding the group programme and what it entails, in the first session of the two week cycle, which is aptly named 'Orientation'. During this session they receive a workbook (not compulsory), with information/worksheet on all the sessions in the program, and the group program (timetable)[2].

Clients who did not attend the orientation group and who were only informally orientated before or after a session, might feel that they did not have enough information to decide if they wanted to participate in the groups.

[2] If a client chose not to take a workbook they still received a folder with a group program (timetable) and clean paper for notes.

In spite of the above-mentioned situation, and quantitative data indicating this concept to be 'the least attained' of all concepts, a possible lack of autonomy and choice was not once identified to be negative in any qualitative data from stakeholders. It was also not observed by myself or mentioned in any of my reflections throughout the study.

5.3.1.3 How was autonomy and choice addressed in my life skill groups?

Facilitating autonomy and choice in my groups, rested on three aspects: Information, goal setting and being open to the needs of the group.

Information on what the group might entail was given as motivation for the stakeholders to decide for themselves if they wanted to attend the group – this strategy is called 'persuasion by explanation', and is identified by Finlay (1993:117) to be one of the positive strategies to encourage attendance. This strategy implicates that the client should understand the reason why they should be involved, what it would entail and that it could be meaningful to them. I would therefore never 'force' a client to attend a group session.

In the first session the stakeholders were also asked by myself what their goal for the week, or the length of their stay was. Some of these goals of the stakeholders were life skill related. I guided the stakeholders in terms of these goals in the orientation session (e.g. goals that were more suitable for addressing by psychologists or psychiatrists). I kept the goals of stakeholders in mind throughout the course of the cycle, and guided them when a specific topic relevant to their goal was addressed. Park (2009:107) remarks that goal setting in the therapy process is important as "…(it) focuses a person's attention and directs his or her effort to those activities most relevant to goal attainment".

I was also lenient and open to the needs of the group. Although a certain topic was allocated to the sessions, it happened that another topic was addressed in the session as it was on the foreground of stakeholders. For instance in cycle 2 the topic for the group was self-image, but the group started to discuss forgiveness and continued on this topic for the rest of the group - I facilitated the group accordingly. Although forgiveness is an aspect that needs to be addressed towards self-image, it was not intended to be addressed for the whole session. This was done within my scope of practice, otherwise stakeholders were directed to their psychologists.

I feel that autonomy and choice were to a large degree present in my life skill groups. Stakeholders were orientated towards the group program and were given the opportunity to

identify their goals (although it was not always life skill related). Stakeholders also had a choice regarding the attendance of groups although they could not choose the specific topic for a group as mentioned.

5.3.1.4 Implications for future practice

To further promote autonomy and choice, I will have to ensure that clients who were orientated informally, due to the fact they did not attend the orientation group, were given more information in order to feel that they had sufficient knowledge to make decisions. I also have to ensure that clients feel that they have a right to not participate, although I motivated them towards participation.

As mentioned before, my group contents were largely pre-determined as the topics, content and group presentation were part of a structured programme. I will consequently in future still have to work within this framework, but as noted above, I will facilitate the group on another topic, if that is the need of the group.

- **Topics of groups**

Even though the topics of groups were predetermined in line with literature on occupational therapy group programs (cf. 2.3.1), data from stakeholders was very positive and all stakeholders in all the cycles felt that the topics of the groups were mostly relevant to them.

In Cycle 1, one stakeholder identified financial problems as a huge stressor and the need for a financial group was indicated by him in the group. This notion was supported by other group members and also indicated in the qualitative data from stakeholders. Stressful life events and worries (such as financial problems), are consistent with literature as environmental stressors, that might cause or aggravate mental illness (American Psychiatric Assosiation 2013:155-188, 189-233, Cara 2005:170-173).

The option for a financial advice group was therefore included (as an option) in the last questionnaire in Cycle 2. The data from Cycle 2 stakeholders confirmed that there was a need for such a group. I think a financial advice group can be very valuable to clients, as financial problems were often, in my experience, mentioned to be a stressor in clients' lives. This need will be brought under the attention of the management of the group program and a recommendation will be made for the implementation of such a group.

5.3.1.5 Conclusion

As described in this section, autonomy and choice is an important and possibly attainable concept of client-centred practice in the PC. By allowing a slight power shift between myself and clients, I can allow them more freedom in the therapeutic process, which facilitates autonomy and choice (Sunsion 2006:41). As facilitator of autonomy and choice, I have to be able to identify the barriers and enablers of autonomy, by understanding their contexts better (Creek & Bullock 2008:120). This improved understanding of context is discussed in the next section.

5.3.2 Contextual congruence

Context of clients include the physical, social, cultural, institutional and spiritual backgrounds and situations in which they live (Stoffel 2011: 773-780). Contextual congruence is about "understanding and recognizing" (Parker 2011:140) these contexts, and considering it in goal-setting and therapy (Creek & Bullock 2008:120-125).

Part of contextual congruence is to understand the situation within which a client lives – the circumstances of each person (Parker 2011:140-141). Sumsion (2006:80) adds that contextual congruence allows therapy to be in tune with a person's roles, interests, environments, culture and values.

5.3.2.1 The challenges regarding contextual congruence

Obtaining background information on clients at the PC, who attend the group program (cf. 2.3.2), remain a challenge. (The therapist do not have the opportunity to gain information prior to or during the first session, as would be the case in a one to one set-up). As mentioned before it was also not possible to have individual interviews with stakeholders before the commencement of the psycho-social group program, read their individual files, or formally assess potential stakeholders. I consequently did not have any background information on the stakeholders or their reasons for admittance. This lack of contextual information made it initially more difficult to relate to clients, or to know when to be sensitive regarding certain subjects. I was also less likely to use relevant examples in the groups. The concept of contextual congruence was thus not attained at the beginning of the group program.

The process of occupational therapy - as described by Reed and Sanderson, Hagedorn, The Canadian Task Force, Fearing & Clark; and Hammell (in Sumsion 2006: 20-22) - advises assessment[3] as one of the first steps following referral, with the aim of determining the possible value of occupational therapy for a client; and then more detailed assessments which will lead to goal setting based on a client's strengths, interests and goals (Creek 2008:66; Sumsion 2006:20). Prior and Duncan (2009:76-77) points out that the benefits of assessment goes beyond the client and therapist, also benefiting the service (i.e. the PC) and profession (i.e. broadening the evidence base of occupational therapy). Assessment may take on different forms, including standardised and non-standardised assessments for individuals (Prior & Duncan 2009:87). No assessment tools specifically for member selection for group therapy could be found in a variety of occupational therapy sources (Prior & Duncan 2009:87; Cole 2012:70; Cole 2008:327-328; Mahaffey & Holmquist 2011:588); with all authors seemingly leaning towards comprehensive individual assessments as the starting point, with referral for group therapy as the second step – if assessment results deems the client as a possible candidate for group therapy.

In the group therapy context, assessment is described as an essential process prior to the selection of group members, to determine whether clients will be able to participate in and benefit from group therapy; as well as to determine the specific goals to be reached throughout the therapy process (Cole 2012:68). Schneider Corey *et al.* (2010:119) explain that there are definite benefits to interviewing and screening potential group-members prior to inclusion in groups, the main benefits being the assessment of a client's ability for group participation (Schwartzberg 2009:178), as well as the client and therapist meeting and exchanging information about the group program. Finlay (1993:118) supports this opinion in suggesting that an interview can encourage attendance, as well as provide an opportunity to clarify expectations and needs.

Having said all of the above (pointing out the benefits of assessment), it is necessary to also consider the opinion of Schneider Corey *et al.* (2010:114-118), writing from a psychology background. They propose that the act of assessing members prior to inclusion in group therapy, is at its best subjective, based on the characteristics of the therapist rather than those of the client. They quote Sonstegard and Bitter (2004:112) as saying: "the selection process itself fails to provide an opportunity for those who need it most". Not wanting to fail clients

[3] Assessment and evaluation are terms which are often used interchangeably. In this study however, assessment is used as the term for 'first or initial evaluation', whereas evaluation is used as the term to assess/measure outcomes and progress if applicable.

who "need it (group therapy) most" (Sonstegard & Bitter 2004:112), I attempted to merge these opinions (for and against pre-selection screening/assessment). I am of the opinion that assessment should be done towards inclusion rather than exclusion; aiming to attain contextual congruence in therapy, as well as for goal setting purposes (Cole 2012:68).

At the PC however, this process of assessment and subsequent member selection does not take place, and Mr HM was therefore not seen for interviewing or screening prior to attending his first group session. I therefor did not know anything about him, apart from his name and room number in the PC, as well as the name of his admitting and treating psychiatrist.

I realised this might be a shortcoming and I was also not certain if the stakeholders had a need to (for instance) talk to me individually before the commencement of the occupational therapy life skill groups. I identified the question in my reflective stage of the study and therefore included this question in the options listed in the stakeholder daily reflections – "Do you think the occupational therapist understood your specific situations and roles, and took it into account in groups?" (Addendum H). According to the findings a number (albeit small) of stakeholders felt the fact that the therapist did not know them well, had a negative effect on their experience of the group.

As the above-mentioned ways to attain contextual congruence was lacking, I needed to look for ways to promote contextual congruence.

5.3.2.2 The promotion of contextual congruence

As mentioned before, it is not possible for individual interviews to be done by myself before commencement of the groups, but a group orientation session as suggested by Schneider Corey *et al.* (2010:119) was presented as the first session in the two week cycle. During this session, group members were provided with information about the group therapy program, questions were answered and group members got to know one another and the therapist. From my observations it seemed that this has been very valuable to the stakeholders in the study. Considering that the indicator of stakeholders not having the opportunity to talk to the therapist before the commencement of the group program, was only mentioned a few times, it seems that the orientation sessions provided the information necessary to build the group on. Later on in the program I often talked to group-members individually after groups or in an individual session if it was requested by the group member.

Although the orientation session provided information to the clients and myself and helped them get to know one another and feel more at ease, I still needed more information to attain better contextual congruence with-in the group set up. I therefore introduced a questionnaire (Addendum F) that stakeholders completed in the first session of the life skill group program. I could thus use relevant examples in my groups and understand a group member's situation better because of this questionnaire.

With clients being informed and having insight in the group therapy program, the client-centred approach was promoted, as was confirmed by my stakeholders in the final questionnaire (during Cycle 1 and 2). This was also reflected in my confidence in our therapeutic relationship, which again has the spin-off effect of 'therapist self-confidence' as promotor of client-centred practice (Sumsion 2006:46).

- **How contextual congruence was addressed in my life skill groups?**
  Although formal assessments were not done, it has to be acknowledged that informal assessment was continually done by myself, and I monitored the progress of the stakeholders, group after group and noted it in my process notes. Stakeholders are also invited to share their goal for therapy during one of the first sessions of the two-week cycle. These goals, however, may be very broad and not only related to group therapy but also individual psychotherapy, for instance that stakeholders wanted to address trauma that they experienced.

  In the occupational therapy process, the step following assessment is treatment development/planning; which is based on clinical reasoning, considering the outcome of assessment as well as goals identified by the client. At the PC however, a set program is followed by all presenters, including the occupational therapist. This program was developed by the group program management, taking into account the 'typical client' admitted to the PC, therefore aiming for some kind of general contextual congruence. The groups are designed and timetabled to build on one another to encourage growth, healing and recovery.
  The last step of the occupational therapy process includes evaluation, which assessed whether outcomes have been attained (Sumsion 2006:139). Evaluation of clients is traditionally not part of the program at the PC or my own practice. In the last group of this study though, clients had the opportunity to share some insights on their road to recovery or share their experiences and journey from when they came into the clinic to where they were then in the last group of the occupational therapy life group program. Clients often

remarked that they were feeling much better, that they knew themselves better and have more hope for the future. According to findings this was also the case with many of the stakeholders in the study.

I regard the lack of formal evaluation of clients after completion of the occupational therapy groups as a shortcoming and therefor implemented the last questionnaire in the study (Addendum H), which focuses on knowledge gained, enablement and satisfaction of stakeholders. The information gained from these questionnaires proved valuable in guiding my insight towards facilitating my life-skill groups.

5.3.2.3 Implications for future practice

The first questionnaire (Addendum F) and orientation session provided me with information to understand better who my stakeholders were, and gave me more insight into their needs, expectations and goals (in order to attain contextual congruence).

In future I will thus continue with the orientation session as an important opportunity to gather contextual information. I will also motivate that we should use the first questionnaire in the occupational therapy program (all OT's) in order to attain better contextual congruence with our clients. I would motivate that an extra tick list should be included to help clients to identify with which 'life skills' they experience problems in their lives, and which they wanted to work on. This will guide the OT more towards the client's goals and give the clients a voice regarding their intervention and aid the therapist in attaining contextual congruence. I would also encourage our practice to use the last questionnaire (or part thereof) in order to ascertain on which topics clients' attained knowledge and felt enabled with.

If I consider the questions posed earlier in this chapter, including if I could work outcome-based and client-centred without formal assessment, individual treatment development and formal evaluation, the answer in my opinion is yes. I feel that the way I facilitate my group as mentioned above, and the questionnaires implemented is valuable and address contextual congruence towards client-centredness within our specific setup at the PC better than a formal standardised assessment and evaluation would do. This can be viewed to be part of the occupational therapy process.

A discussion on information obtained by the first questionnaire (Addendum F) that helped to attain contextual congruence will now follow.

5.3.2.4 Conclusion

I now had a better understanding of Mr HM's contexts and the goals he wanted to achieve. Consequently, access to the discussed data aided me in attaining contextual congruence (as discussed previously) and building a therapeutic relationship with stakeholders towards partnership and responsibility.

5.3.3 Partnership and responsibility

'Partnership and responsibility' is the concept of client-centred practice that requires the therapist to take the position of "facilitator rather the director", allowing the client to take more responsibility for their own wellbeing. A healthy partnership is based on a therapeutic relationship, where the therapist offers knowledge and support, and the client - as partner - equally brings knowledge - knowledge of his own context and of living his own life (American Occupational Therapy Association 2014:S12-S13; Sumsion 2006:4).

5.3.3.1 The promotion of partnership and responsibility

The therapeutic relationship and therapeutic use of self has always been aspects I regarded as very important in my work with clients, and I've come to realise the importance of portraying specific skills such as counselling, listening, empathy and feedback - which are also coined by Hagedorn (1995: 262-263) as skills that facilitate the therapeutic relationship.

Therapeutic use of self, as the "deliberate use of self by the therapist to prompt/enable a positive therapeutic outcome by reacting or responding to a client in their milieu" (Martin & Wheatley 2008:242), also promotes the collaborative partnership by enabling positive outcomes.

5.3.3.2 The challenges regarding partnership and responsibility

In order to establish partnerships, therapeutic relationships had to be formed between the therapist and stakeholders. As mentioned before the opportunity for this was limited as I didn't have individual interviews with the stakeholders beforehand. I therefore had to draw strongly from my therapeutic use of self, in order to establish therapeutic relationships, in an attempt to promote partnership and responsibility.

In my experience, and as coined by Sumsion (2006:46-48) possible barriers for partnership exist in both the client and the therapist, and these are discussed below.

(a) Client barriers

In client-centred practice, the therapist aims to allow the client more control in the intervention process, which inherently requires the client taking responsibility (American Occupational Therapy Association 2014:S12-S13).

However, the following may impact negatively on a client's ability and/or willingness to enter into a more collaborative therapeutic relationship as opposed to the traditional relationship of 'therapist as expert and client as passive and vulnerable'.

Socio-demographic factors: Clients from specific backgrounds may have more difficulty accepting the invitation towards power sharing. Sumsion (2006:50) mention that older people may tend to feel vulnerable in the presence of health professionals, while younger women tend to be more ready for active sharing and collaboration.

Educational and cultural background: Clients with a limited education may have trouble understanding the rationale behind and benefits of the client-centred process, and therefore not value it sufficiently to actively participate. Along the same lines, people from specific backgrounds may feel it a waste of time to engage in the client-centred process, and expect a certain formal demeanour of health professionals – thereby actually putting them in the role of 'expert' and 'provider of health' (Sumsion 2006:50).

Limited problem-solving skills: A certain level of problem-solving skills is almost a prerequisite for being able to engage in the client-centred partnership; and without it, the

therapist is required to take on a more active role than she might have planned (Sumsion 2006:50).

(b) Therapist barriers

From own experience I've seen that my own emotional state (being stressed or upset) influenced my facilitation of my group (cf.4.2.4.3), as well as how comfortable I felt with sharing more power with the clients. Sumsion (2006:46) explains that it requires much confidence from a therapist to 'surrender' some of her power by allowing the client to be more active in parts of the therapeutic process. This may be an explanation of how my emotional state can create a challenge regarding the promotion of collaborative partnerships with clients.

Having said this, it is also important to note that Hagedorn (1997:21) offered some strategies for strengthening your therapeutic self, ultimately with benefit to the collaborative partnership and the client's wellbeing.

5.3.3.3 How was partnership and responsibility promoted in my life skill groups?

In my aim to promote partnerships with stakeholders, I focused on fostering the therapeutic relationship by therapeutic use of self. I listened to stakeholders and showed empathy. I made efforts to understand my client's contexts better (cf. 5.2), to allow me to offer more contextually congruent therapy. I also explained to stakeholders in the orientation session the importance of their commitment towards their own recovery; as well as the importance of taking responsibility for themselves.

Findings indicated that stakeholders felt they could relate to me (cf. 4.2.4.1 (b)), that I had empathy with them and that they felt safe in the group. They also felt that they received useful information and that they could identify with the examples used (cf.4.2.4.). No suggestions were made by stakeholders regarding how I presented myself. (These findings correspond with the concept of therapeutic use of self (cf. 5.3.3), which is regarded as an agent of partnership.

The development of the therapeutic relationship with stakeholders was addressed in the orientation group by attempting to facilitate collaboration with the stakeholders (Townsend & Polatajko 2007:107). I recognised their backgrounds as well as their objectives towards recovery, and would mention this at appropriate times throughout the orientation session and following groups. Throughout the two week cycle - the therapeutic relationship allowed

contributions from the client as well as the therapist (The American Occupational Therapy Association 2014:S12), resulting in power sharing (Sumsion 2006: 125-126).

In this study it seemed that stakeholders mostly felt that they took responsibility for themselves. Results (cf. Table 4.10) from the last questionnaire (Addendum H) showed that most stakeholders felt they were given the opportunity to take responsibility for themselves in occupational therapy groups. All but two stakeholders felt that they did. These two stakeholders noted that they were given the opportunity to take responsibility 'in some degree'. They did not offer any explanation for their answers.

Finally, with regards to the effect of my own emotional state on the group: I believe it is possible to still have an effective group even though I as presenter may be feeling unwell, upset or stressed. Both Hagedorn (1997:21) and Schneider Corey *et al*. (2010:19-33) encourage continuous self-reflection and self-awareness as the answer to not letting personal problems affect the facilitation of groups. You, however, should be aware of the fact that you mood/emotional state might influence the group and focus on not letting it effect the therapy or the group process negatively.

5.3.3.4 Implications for future practice

With collaborative partnerships being a cornerstone of client-centred practice, I will forever be looking for opportunities to further the therapeutic relationship with my clients, as well as more swiftly using my therapeutic use of self. Both these factors are documented to promote partnerships and responsibility.

Furthermore it will be required of me to remain cognizant of specific barriers clients may experience in their 'ability' to engage in a collaborative relationship (as opposed to a more traditional healthcare practitioner - client relationship). Collecting much contextual information will also provide information on which barriers my client may experience.

Finally, it is important to maintain a high level of self-awareness, in the sense of being aware of my own experiences, including my emotional wellbeing and other factors that may impact my effective facilitation of groups. Only if I am aware of my own barriers, can I actively employ appropriate strategies to maintain my ability to offer therapy in such a way that I am promoting the collaborative partnerships with my clients.

5.3.3.5 Conclusion

'Client and therapist as partners' – an approach that allow people to take more responsibility for their own intervention programs. An approach that also requires some accessibility and flexibility on the part of the therapist, as described in the next section.

5.3.4 Accessibility and flexibility

The accessibility of services (as a key concept of client-centred care) is not described in detail in literature; not even in the same sources that provide much detail about the other key concepts. For the purposes of this study, "accessibility and flexibility" - as key concept for client-centred care, is associated with the needs of clients.

5.3.4.1 The promotion of accessibility and flexibility

The promotion of accessibility and flexibility is, as per its definition, an endeavour that requires much flexibility. For example, having a client with visual impairment in the group, might impact on the activities chosen for the group. Along the same lines, but requiring much different adaptation, if a client with hearing impairment joins the group the activities would once again be chosen very specifically to allow the client access to the whole group process or as much of it as possible.

An agent of accessibility and flexibility may therefore be regarded as having an acute awareness of client's needs (specifically regarding the performance components, i.e. bodily functions and structures); and possessing the willingness to adapt therapy to allow optimal participation for all members.

5.3.4.2 The challenges regarding accessibility and flexibility

According to the findings, it seemed that all stakeholders (Cycle 1-2) felt that accessibility and flexibility was offered. As mentioned before, this might be due to the set-up of the PC (all the facilities are in the hospital, for example the bedrooms, dining room, group rooms and consultation room). Everything in the hospital work together to accommodate and support the psycho-social group program. This might have also made it easier for stakeholders to attend the groups.

The main challenge for myself in offering accessibility to all members, is the fact that I often have no time for preparation (for example, when arriving at the venue to present a group, I would meet a client with very specific needs for the first time, requiring me to make on-the-spot adaptations to activities, seating plans etc.).

5.3.4.3 How was accessibility and flexibility promoted in my life skill groups?

Throughout the sessions, I was also sensitive to stakeholders who felt that they didn't fit in or were different than other group members. An example of this was a stakeholder with a hearing impairment. I observed that she found it difficult to follow in the group - I therefor asked her after the conclusion of the first session to stay behind. We had a conversation in which she explained to me that she could not hear very well and depended on lip reading. In my groups I made sure that I faced her when talking and also summarized discussions from the group for her, if I saw that she lost track of the conversation. This was a challenge to me but brought about that the stakeholder were part of the group and attended most of the life skill sessions. She mentioned that she valued being part of the group as she always felt like an outsider. She had the following remark (in a written reflection) on the fact that I addressed her needs: *…'She adapted for my needs and I appreciate it immensely'.*

The concept of accessibility was also on the foreground with the way I facilitated the group and presented information (use of language, vocabulary etc.). I realised from the first questionnaire that only four of the ten stakeholders in cycle 1 had tertiary education, four had grade 12 and two only grade 10. I therefore took that into account when presenting/explaining something in order to make it accessible to all the clients in the group. The stakeholders reacted in the following way in their reflections: *'She ...explains everything nicely'* and *'Information was presented to me in a compact way that I could understand…'*

As facilitator of the group, I also had to be flexible in order to accommodate stakeholders' needs. For example in Cycle 2 I had an 'extra group' (catch up group) for two stakeholders who missed a session that was important to them. This is not expected of an occupational therapist, but due to the fact that stakeholders sometimes missed a lot of groups and were committed to the group; I felt that I wanted to accommodate these stakeholders. The downside to this is that the session was not really a group session and the therapeutic value of the group might not have been the same as within the group.

5.3.4.4 Implications for future practice

As mentioned (cf. 5.3.4.1), it is nearly impossible to pinpoint guidelines for offering accessibility and flexibility; apart from maintaining an acute awareness of clients' needs, with willingness and flexibility to adapt intervention according to client's needs.

A very practical implication might be to arrange with nursing staff (who handles admissions), to indicate on the client's demographic form any 'special needs' with regards to the successful attendance of groups. Nursing staff could then communicate these special needs with myself as well in advance as possible, to allow for suitable adaptations to be made to groups.

5.3.4.5 Conclusion

As facilitator one has to be flexible with regards to offering maximum accessibility, for issues often revolving around physical limitations, which are often reported by nursing staff or clients themselves. Mr HM, for instance was often very anxious in the groups. I therefore positioned him near the sliding door that opens up to the balcony and left if slightly open. This made him less anxious and enabled him to participate in the group. With clients bringing very unique needs to the group venue, accessibility is sometimes not sufficient and I remain challenged in offering a service that is optimally aware of and respectful towards the diversity of stakeholders.

5.3.5 Respect for diversity

Parker (2011:199) explains that it is important that the therapist should respect the client's values and goals, which may be diverse and very different from her own. She warns that the therapist must take care not to force her own values and goals onto her client. Mr HM might for instance be from a different religion than me. He might also not see his aggression towards others as a problem that need to be addressed, as I maybe would in choosing a goal for him.

5.3.5.1 The promotion of respect for diversity

In order to cultivate respect for the diversity in my clients, I have to be aware of my own values, goals and especially biases. It is highly advised to seek support in understanding differences (Sumsion 2006:69) and learning to understand that my clients' values may influence their approach to healthcare (Sumsion 2006:81).

5.3.5.2 The challenges regarding respect for diversity

A lack of contextual information - especially early in the two week cycle, may lead to apparent insensitivity and bias towards clients with values different to my own or the majority of group members.

5.3.5.3 How was 'respect for diversity' promoted in my life skill groups?

This concept of client-centred practice seems to have been present in my life skill groups, as all except one stakeholder reported that I respected their opinion, values and goals in the sessions and their needs were satisfied during the life skill groups.

I addressed this concept by (firstly) being aware of my own biases and values. Secondly I got to know my stakeholders (contextual congruence) in order to show respect regarding diversity in the group and to accommodate stakeholders within their own roles, value-, cultural- and belief system.

An example of how I had to address this concept was in terms of the population in my cycle 1 group. After viewing the first questionnaire completed by stakeholders, I realised that four of the ten stakeholders were housewives. I therefore accommodated them by using examples that was not only applicable in the formal workplace, but also within their frame of reference. Stress is often seen as a corporate illness and therefore one can easily focus on formal work related examples. Having had the knowledge on who my clients were, gave me the advantage to accommodate my stakeholders accordingly.

5.3.5.4 Implications for future practice

Once again, the importance of obtaining sufficient contextual information as early as possible in the intervention process is highlighted. Also, as with enhancing my therapeutic use of self, it is crucial to maintain a high level of self-awareness.

5.3.5.5 Conclusion

The therapeutic relationship may be severely scarred, should I not show respect for diversity. It is therefore of utmost importance to cultivate sensitivity regarding my clients' values - even if they are different to my own.

5.3.6 Enablement

Enablement, a term increasingly used in occupational therapy literature, is used as a verb – in that the therapist is aiming to 'enable' (hence optimising or improving) the occupational performance of her clients. It is the process by which the therapy outcomes that have been agreed upon by the client and therapist, is reached.

Enablement is regarded as one of the core competencies of occupational therapists, with the view of improving her clients' occupational performance Townsend, Cockburn, Thibeault and Trentham (2013:99). In its purest sense it requires and/or allows the client to take an active role in therapy; towards reaching the therapy outcomes that have been agreed upon by the client and therapist – and is therefore aligned with client-centred care (Townsend, Beagan, Kumas-Tan, Versnel, Iwama, Landry, Stewart & Brown 2007(c):98).

One concept inherent to understanding the theory around enablement is the continuum of enablement, ranging from effective enablement (best practice), through minimal- and missed enablement, to ineffective enablement (Townsend *et al.* 2007(b):130-132). This is of course a subjective concept and only through critical reflection will a therapist be able to realise the barriers to enablement in her own practice. It was through this lens that I considered my findings (especially taken from the reflections and the last questionnaire – Addendum F, H) for the discussion below (cf.Table 4.6 – Table 4.8).

The stakeholders felt more enabled towards the end of the 2 week program, but their journey towards enablement and their experience of the life skill groups were influenced by different indicators, external and internal; that are discussed with the levels of enablement below.

5.3.6.1 The challenges regarding enablement

I remind the reader about the continuum of enablement (Townsend *et al.* 2007(b):129), ranging from effective to ineffective enablement - the following discussion will be guided by it.

Missed enablement - (Townsend *et al.* 2007(b):131): In spite of all the pointers towards effective enablement, stakeholders also reported aspects possibly indicative of missed enablement. Some factors that were reported as external indicators (cf. Table 4.6), were mentioned as specific resources affecting stakeholders' physical comfort. These included the chairs being uncomfortable and noise outside the group therapy venues. Other indicators influencing stakeholders' participation in groups and therefore enablement included factors like the side effects of medication, the fact that stakeholders were worried about things outside of the group, the stakeholders' psychical condition (pain and illness) and stakeholders finding it

hard to focus and concentrate. Stakeholders also felt anxious upset or depressed and didn't sleep or didn't sleep well the night prior to the group session. These indicators were external indicators that were not directly associated with the group I facilitated and I didn't have control over this, but it still had an effect on the stakeholders' experience of the group and therefore their enablement. Although the clients' physical state has always been considered by myself in some degree – findings show that this aspect has a huge influence on clients experience of the group and therefore enablement. I will in future now be more alert and focused on clients' physical state and try to attend to their needs as far as possible.

Group attendance - and the fluctuation thereof - was a major pointer towards missed enablement. Stakeholders' complaints about being 'taken' or 'held' from groups to attend appointments with their psychiatrists or psychologists were frequent. I acknowledge that attending therapy sessions with other medical professionals are also part of the larger process of enablement. However, the scope of this study and dissertation is limited to occupational therapy and when clients miss out on occupational therapy sessions; their *occupational therapy enablement* is limited.

The group members thus varied with every session and as Gupta (2005:5) explains, this may cause the group dynamics to change, making it harder to establish group cohesion. This aspect possibly thus influenced the cohesion of the group, although it did not seem to show that much in the quantitative data (cf. Table 4.4 & 4.5), as many positive aspects were mentioned that show there were good cohesion in the group especially the second week of the cycles. The interruption of groups is also seen as a negative aspect towards enablement.

Minimal enablement - (Townsend *et al.* 2007(b):131): the only pointers towards 'minimal enablement' was deducted from my own reflections, and not from stakeholders'. I feel that the set group program may be prescriptive and therefore limits enablement. However, this factor may be countered by my own flexibility and adaptive skills (as enablement skills), in that I will allow (and have done so in the past), a group to steer towards another topic if required by stakeholders' immediate needs.

Furthermore, in reading stakeholders' positive remarks about myself as a person, as well as my skills as therapist, I feel that stakeholders may become over-reliant on me, having too much faith in me. This is mentioned here to caution me to self-awareness, to direct my own behaviour to not facilitate clients to become overly dependent (and therefor disabled) on me.

Ineffective enablement - (Townsend *et al.* 2007(b):131): No pointers of ineffective enablement were recognized in my findings.

5.2.6.2 How was enablement addressed in my life skill groups, i.e. how did I enable stakeholders?

Many indicators had an influence on the enablement of stakeholders.

Effective enablement - (Townsend *et al.* 2007(b):131): I learned that stakeholders found the group process to be a mutual and valuable process, also in correlation with the experience of Yalom's therapeutic factors (Yalom 1995:1). These factors were experienced by stakeholders and indicated towards the experience of effective enablement. The instillation of hope was apparent in the groups, as stakeholders often indicated at the commencement of the group program that they seemed to feel relieved that they will receive help and often mentioned that they had hope that they will get better. Other factors included that stakeholders felt comfortable and safe in the group, they could identify with other stakeholders, learned from one another and realised that other group members also experienced difficulties in live.

Also a therapeutic factor, self-understanding, of stakeholders improved. It is an intellectual component that can be explained as insight into himself/herself (Cole 2012:33). This self-discovery has two sides to it, it can be positive in the sense that it can help you to learn new things about yourself for example strengths and abilities that can enhance your quality of life or negative in the sense that you have to accept past negative thoughts or behaviour as part of who you are (Cole 2012:33). In order to work towards enablement where the stakeholder can achieve what they want to achieve the stakeholder first has to become aware of their own behaviour, their way of thinking and their needs – they have to get to know themselves better in order to understand themselves better and change their behaviour.

Stakeholders reported that their beliefs were taken into account by me, and that the group program was congruent with their contexts (i.e. topics on the program were indicated as relevant). It is encouraging that stakeholders reported praise of my expertise as group therapist and indicated in the quantitative data of reflection that they could relate with me; as it seems to have had a positive influence on enablement of stakeholders.

5.3.6.3 Implications for future practice

Enablement is seen as one of the core competencies of occupational therapists, with the view of improving her clients' occupational performance. It is also very important in order for the client to grow in terms of their occupational performance (Townsend *et al.* 2013:99). Enablement is influenced by many indicators causing it to be effective or ineffective. In order to assure effective enablement I will have to address indicators that cause in-effective enabling as far as possible and focus in my groups on indicators influencing the group process and also enablement positively. For instance to ensure that therapeutic factors as described by Yalom (1995:1) is facilitated as well as my 'therapeutic use of self' as it had a positive influence on stakeholders' experience of the group and therefore enablement.

5.3.6.4 Conclusions

Enablement is one of the main tools in my hands as occupational therapist, in aiming for improving my clients' occupational performance. When applied in its' purest form, it allows the client to take an active role in therapy. Findings confirmed that stakeholders experienced effective enablement during their attendance of the two week group therapy program. However, their experience of enablement has been influenced by many factors – internal and external, many of them out of my control (as occupational therapist).

5.4 Summary

Findings were reported in Chapter 4, and discussed along with literature, in Chapter 5. The discussion of results were guided by the key concepts of client centred care, alongside with specific internal and external indicators playing positive and negative roles in stakeholders' experience of enablement through attending the group therapy program.

Realising that many of these factors are, and will remain, outside of my control as an occupational therapist working in a larger system, my focus will continue along these lines: to offer best practice, based on a client-centred service as well as optimal facilitation of therapeutic factors in my groups.

Chapter 6 will conclude the study, also making recommendations and pointing out the limitations of this study.

CHAPTER 6

CONCLUSIONS, RECOMMENDATIONS AND LIMITATIONS

6.1 Introduction

In the previous chapter, the findings relating to this study were discussed and interpreted along with relevant literature.

This chapter concludes the study by firstly addressing the conclusions in the study, referring briefly to findings, but focusing more on recommendations for therapy and further research. Following the recommendations, the limitations of the study will be discussed, and finally the dissertation will be concluded.

6.2 Conclusions

The conclusions relating to the objectives of the study are now discussed.

6.2.1 Conclusions regarding the objectives of the study

The objectives of the study were to utilise a collaborative effort with clients from both an insider and outsider perspective in order to:

- Cultivate personal reflexivity and gain a greater understanding/insight of how **external indicators** may influence the life skill program.
- Cultivate personal reflexivity and gain a greater understanding/insight of how **internal indicators** may influence the life skill program.
- Gain insight into how stakeholders perceive the contents and facilitation of the life skill program to support their individual needs during admittance (client-centredness of life skill program and enablement of stakeholders).

The mentioned objectives are used to summarise the findings as presented in Chapter 4 and discussed in Chapter 5.

6.2.1.1 External indicators

Findings indicated that external indicators had an influence on the stakeholders' experience of the life skill groups.

I accordingly gained insight into which external indicators had an influence on the stakeholders' experience of the group. These indicators are divided in external indicators that had a positive influence and external indicators that had a negative influence on the stakeholders' experience of the life skill groups.

(a) External indicators that had a positive influence on the stakeholders' experience of groups

The following indicators featured in the findings as external indicators that had a positive influence on stakeholders' experience of the group (cf. 4.2.3.4):

- Stakeholders' moods were better;
- Stakeholders slept well the night prior to attendance to the group session;
- Stakeholders could focus and concentrate well in the group sessions;
- Stakeholders did not have side effects from medication – their medication worked well; and
- Stakeholders felt motivated (committed) to participate in the groups.

It is noted that the aspects of stakeholder's focussing and concentrating well or not well in the group sessions and stakeholders who had and didn't have side effects from medication was both indicated by stakeholders. The positive indicators were however much higher than the negative indicators. This shows that stakeholders differed in terms of their experience related to certain indicators.

These were all indicators that were not directly associated with the group process I was involved in, and mainly indicators influenced by medication, the overall therapy process (including individual therapy) and potentially hope due to stakeholders receiving help and support which may have influenced it.

(b) External indicators that had a negative influence on the stakeholders' experience of groups

The external indicators that were identified to have had a negative influence on the stakeholders' experience of groups were considerably more than the positive indicators. Relevant indicators will be grouped together for the conclusion.

The following indicators were mainly influenced by the stakeholders' diagnosis and physical condition as well as medication (cf. 4.2.3.2):

- Stakeholders were worried about something outside of the group;
- The side effects of stakeholders' medication;
- The stakeholders' physical condition;
- Stakeholders found it hard to focus and concentrate;
- Stakeholders felt anxious, upset or depressed; and
- Stakeholders didn't sleep at all or didn't sleep well.

Aspects that management should consider in future:

- The interruption of group sessions;
- Breaks between group sessions were too short;
- Stakeholders were physically uncomfortable; and
- The cohesion of the group changed when a group member left the group or when new members joined the group.

The cyclical nature of AR and the practical implication of life skills group development motivated me to consider how to address the following items (cf. 4.2.3.3):

- Too little time for groups; and
- Group and stakeholder unpunctuality (the group starting late).

The internal indicators that had an influence on the stakeholders' experience of the life skill groups will follow next.

6.2.1.2 Internal indicators

In this study, internal indicators referred to factors directly associated with the group process that I was involved in, for example my facilitation of the overall group process and presentation of the group session.

(a) Internal indicators that had a positive influence on the stakeholder's experience of the group

The following indicators were underlined in the findings to have had a positive influence on stakeholders' experience of the life skill groups (cf.4.2.4.1.):

- Stakeholders received useful information (*imparting of information[4]);
- Stakeholders got to know themselves better (*self-understanding);
- Stakeholders felt comfortable within the group (*cohesion);
- Stakeholders realised that other people also experience difficulties in life (*universality);
- Stakeholders felt safe in the group – they felt that they belong (*cohesion);
- Stakeholders could identify with one of the other members of the group (*universality);
- Stakeholders learned something from another group member (*interpersonal learning);
- Stakeholders could socialise with other group members and didn't feel alone (*development of socialising techniques);
- Hope was instilled in the stakeholders*;
- Therapeutic factors made the group more effective and being a member of the group was highly valued by the stakeholders;
- Stakeholders related with the presenter;
- Stakeholders could identify with examples being used in the group;
- The use of activities in the group made the group more effective; and
- The stakeholders' moods improved towards the end of the cycle.

It is evident from the mentioned indicators that the stakeholders valued being a member of the group above all and that especially the therapeutic factors as described by Yalom (1995:1) contributed towards the positive experience of stakeholders. Stakeholders

[4]An * indicates a therapeutic factor as described by Yalom (1995:1).

seemed to be able to relate to me as facilitator, felt that they received useful information and found that they could identify with examples I used. It was also recognised that activities and worksheets used in the group was relevant and made the experience of the group more meaningful. Stakeholders' moods improved towards the end of each cycle.

(b) Internal indicators that had a negative influence on the stakeholders' experience of the group

Internal indicators that had a negative influence on the stakeholders' experience of the group follow next (cf.4.2.4.3).

(i) My stress or emotional state as presenter

Despite the fact that I realised that my emotional state could have an impact on the group I facilitated as experience at two occasions during the study that I was specifically aware of - it seemed to not have an impact on my facilitation of the group as it was not noted by the stakeholders.

(ii) I addressed the following indicators throughout the study

- Too little time for stakeholders to reflect; and
- suggestions towards the group sessions.

Findings highlighted the fact that several indicators influenced stakeholders' experience of groups. These indicators were described as internal and external indicators, as well as positive and negative. I acknowledged the impact of these indicators on stakeholders' experience of the group, although I might not be able to address them.

6.2.1.3 Effect of the life skill groups on stakeholders

(a) Concepts of client-centredness (cf. Table 4.10)

Findings indicated that the concepts of client-centred practice were very important in addressing enablement. Some concepts of client-centred care were better addressed than others within the occupational therapy program.

"Accessibility and flexibility" and "respect for diversity" seemed to have been addressed very well as stakeholders all indicated this to have been positive. "Enablement" was also indicated to have been realised by most stakeholders. "Contextual congruence", "partnership and responsibility" and "autonomy and choice" were partly addressed as indicated by stakeholders; however, there were shortcomings regarding these concepts, which will have to be attended to in future (cf. 5.3.1, 5.3.2, 5.3.3).

(b) Satisfaction (cf. Table 4.10)

Stakeholders seemed to have felt satisfied with the occupational therapy service rendered and felt that the occupational therapy groups played a positive role in their recovery/healing. All in all the stakeholders' attitudes towards occupational therapy groups were good and they would recommend participation in the occupational therapy life skill groups to other people.

6.3 Recommendations

6.3.1 Recommendations regarding future therapy

The findings discussed in Chapter 5 gave me a better understanding of the indicators influencing my occupational therapy life skill groups and the impact thereof on stakeholders. I will now attempt to make recommendations according to these findings.

6.3.2 External indicators influencing groups negatively

The following recommendations are made to address external indicators influencing groups negatively at the PC, for improved quality of intervention in order for the service to be enhanced:

(a) The interruption of groups

Although this aspect is very hard to address within the PC's daily program, as explained in Chapter 4, it will be brought to the attention of the management of the group program for possible intervention.

(b) Breaks between groups were too short

A recommendation will be made to the group program management to review the current group program at the PC to have breaks after every session and to lengthen these breaks.

(c) Stakeholders were physically uncomfortable

The aspect of chairs that were hard or uncomfortable will be brought under the attention of the management of the PC. The possibility for other chairs or cushions for the current chairs will be proposed. I should also be more aware of the physical state of clients and their needs in terms of these as it influences their experience of the group and therefore enablement. A very practical implication might be to arrange with nursing staff (who handles admissions), to indicate on the client's demographic form any 'special needs' with regards to the successful attendance of groups (for instance disability or pain). Nursing staff could then communicate these special needs with myself as well in advance as possible, to allow for suitable adaptations to be made to groups.

(d) Availability of contextual information

Another recommendation would be that the contextual information attained by the questionnaire in the orientation session should be made available to all the team members by means of, for example, a computer folder that can be accessed by the team members. This will promote contextual congruence in order to enhance the value of the groups.

(e) Financial advice group

During the AR study stakeholders identified that they had a need for a financial advice group as the management of their finances were seen as a stressor to many stakeholders. A recommendation will therefore be made to the management of the group program to look into the possibility of a financial advice group to be included in the program.

(f) Anxiety group

Recommendations will be made to the management of the group program and the owner of the occupational therapy practice to look into the anxiety group, if it is still valuable and if another name for the group should be considered.

6.3.3 Recommendations regarding the internal indicators influencing groups positively

From the findings in the study it is evident that certain internal indicators enhanced the group process, stakeholders' experience of the group as well as enablement of stakeholders.

The following factors need to be incorporated into my psycho-social life skill groups to ensure best client-centred practice.

- To uphold client-centredness in groups is essential – all concepts of client-centredness should thus be addressed during groups, e.g. respect for diversity (cf. Figure 4.4).
- Being a member of a group – feeling safe and belonging – was greatly valued by stakeholders. The therapeutic factors as described by Yalom (1995:1) enhance the group process and are very important for recovery and should be encouraged by the therapist.
- The therapeutic use of self is very important to build a therapeutic relationship and to promote enablement of stakeholders. The OT should therefore cultivate self-awareness and tend to her own emotional well-being.
- Activities, including projective techniques such as using toy animals, a collage and the use of worksheets, enhanced the experience of stakeholders regarding the groups positively and seemed to make the group more effective (cf. 4.2.4.2(b)). The use of activities is thus recommended and important to use as part of the occupational therapy scope.

6.3.4 Recommendations for sharing insight and professional gains

Findings will be made available to other occupational therapists or team members during team meetings, presentations at speciality interest groups, national conferences and in scientific publications, as:

- The evidence in this study may provide guiding insights and possibly some principles for other occupational therapists presenting life skill groups within sub-acute mental health settings in South Africa.

- This study could add to the body of knowledge on psycho-social occupational therapy life skill groups and could contribute towards a greater understanding of client-centred approach with regard to psycho-social life skill group programs for occupational therapy.
- My experiences might also encourage other OTs to engage in reflexivity for advancing best practice that is client-centred for their clients in their specific context.

6.3.5 Action enquiry impact

- The first questionnaire generated by this AR study was already implemented by all the OTs at the PC prior to the conclusion of the study. It was also decided that we will develop a questionnaire similar to the last questionnaire used in the study to appraise the outcome of our groups.
- Mindful therapy practice was encouraged by the example of an action research process and whenever a new topic was introduced in the occupational therapy life skill program, the OTs made use of a written structured reflection to revisit and assess the impact of the changes.
- The action research process motivated three colleagues to formally review the paediatric group program.

Personally, I see the above-mentioned aspects as a positive step towards the occupational therapy team embracing outcome based intervention by generating outcome based intervention programs – more research in this area is vital.

6.3.6 Recommendations with regard to further research

The following recommendations based on the findings and limitations of the study are made regarding future research on psycho-social occupational therapy life skill groups and client-centredness.

- The study may be repeated by other OTs within their own setting in order to gain insight into their occupational therapy groups, their impact on it and indicators that influence it as well as the client-centredness of the service.
- If an occupational therapy colleague were to duplicate this action research approach within their life skill group presentation, it could promote transferability of the findings.

- An AR study can provide a way to gain insight into other occupational therapy programs at the PC, for instance the teenage life skill groups, towards best client-centred practice.
- Another study can explore different activities and ways to present the contents of the occupational therapy life skill groups that is relevant to our population at the PC. This will ensure a broader activity-databank for psycho-social occupational therapy groups within a sub-acute setting in a South African context.

6.4 Limitations of the study

- In the first questionnaire I asked certain questions in order to address contextual congruence. Sumsion (2006:80) advocates that the information needed to address contextual congruence should include life roles, marital status, interests, environments, culture and values. These questions were not included in the first questionnaire and therefor inhibited a holistic view of the background and social context of the stakeholder.
- Another limitation to my study could have been the range of questionnaires and reflections that my stakeholders had to complete; it was time-consuming and could have been taxing to complete. This might have resulted in less detailed information, as mainly checklists were completed and seldom supported by descriptive examples.
- A fact that also had to be taken into account was that I was known to the stakeholders and a therapeutic relationship was formed, which might have influenced the honesty of the stakeholders' reflections. As this could have been a disadvantage and influence the trustworthiness of the study (cf. Table 3.8), I reiterated the purpose of the study and the importance of stakeholders' honesty in order to improve the program throughout the study. Stakeholders were assured that their responses would not influence the therapist-client relationship or influence the researchers' feelings and behaviour towards the stakeholder. The reflections were part of AR where the stakeholders were actively involved, committed and informed of their role in the process and that should have fostered the willingness and responsibility to be honest and serious when completing reflections. On the other hand, this might not have been a disadvantage as stakeholders may have felt more comfortable and relaxed about sharing their feelings and perceptions with a therapist they knew and had a therapeutic relationship with. It was positive that the stakeholders had the opportunity in terms of the reflections to also make positive remarks regarding me as facilitator of the group.

6.4.1 A paradoxical limitation of the study

- The amount of data that I had generated during the cycles, including daily journal entries and process notes, as well as the amount of data acquired that I had to process and analyse, was extensive. This included qualitative and quantitative data – especially the qualitative data analysis and the quantitative data input into Microsoft Word were time consuming. This put pressure on me during the time of the cycles and it also might have influenced the quality of my reflections, process notes and daily journal entries.

6.5 CLOSURE

Evidence is important to demonstrate that occupational therapy plays an essential role in the healing and recovery of the mental health client. The aims and objectives of the study were addressed as I had gained insight into the internal and external indicators that had an influence on the stakeholders' experience of the life skill groups, as well as the effect of these groups on the stakeholders. **Action Research allowed me a way to gain insight into my current occupational life skill groups while continually addressing client-centred practice for the people I serve.**

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ADDENDUMS

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1 Addendum A: PC psycho-social group program.

2 Addendum B: Information and consent document: Stakeholders.

3 Addendum C: Letter of permission to management; the PC.

4 Addendum D: Letter of permission to owner of private occupational therapy practice.

5 Addendum E: Information letter to Psychiatrists and other stakeholders.

6 Addendum F: First Questionnaire.

7 Addendum G: Reflection (Cycle 1).

8 Addendum H: Last Questionnaire.

9 Addendum I: Reflection (Cycle 2).

10 Addendum J: Reflection (Cycle 3).

11 Addendum K: Procedures of data collection.

Addendum A: PC psycho-social group program

Week 1

	MAANDAG	DINSDAG	WOENSDAG	DONDERDAG	VRYDAG
07:30-08:15	**Ontbyt**	**Ontbyt**	**Ontbyt**	**Ontbyt**	**Ontbyt**
08:30- 09:30		**MIDDELS EN MEDIKASIE** Psigiater	**MY PRENTJIE VAN MYSELF** Arbeidsterapeut	**VERSTAAN JOU SIEKTE** Psigiater	**TERAPEUTIESE AKTIWITEITS-GROEP**
09:30-10:30	**VERWELKOMING** Sielkundige	**ONTDEK JOUSELF** Arbeidsterapeut	**GEïNTEGREERDE BEWEGING** Sielkundige	**SELFHANDHAWING EN GRENSE** Arbeidsterapeut	Arbeidsterapeut
10:30-10:45	**TEE**	**TEE**	**TEE**	**TEE**	**TEE**
10:45-11:45	**ORIëNTERING** Arbeidsterapeut	**GEïNTEGREERDE BEWEGING** Sielkundige	**ONTDEK KINDERJARE PRENTJIES WAT VERHOUDINGS BEïNVLOED**	**GEïNTEGREERDE BEWEGING** Sielkundige	
11:45-12:45	**MY ERVARING VAN STRES I** Arbeidsterapeut	**SELFBEELD** Arbeidsterapeut	Sielkundige	**SELFHANDHAWINGS-TEGNIEKE** Arbeidsterapeut	
12:45-14:15	**ETE**	**ETE**	**ETE**	**ETE**	**ETE**
14:15-15:15	**MY ERVARING VAN STRES II** Arbeidsterapeut	**EMOSIES** Sielkundige	**ONTSPANNINGSTERAPIE** Arbeidsterapeut	**14:30 PSIGE VAN DIE MENS**	
15:15-16:15	**ONTSTAAN VAN SIEKTE VEERKRAGTIGHEID EN GENESING** Psigiater	**EET VIR GESONDHEID** Diëetkundige	**TERAPEUTIESE AKTIWITEITS-GROEP** Arbeidsterapeut	Sielkundige	
16:30-17:30	**ETE**	**ETE**	**ETE**	**ETE**	**ETE**

Week 2

	MAANDAG	DINSDAG	WOENSDAG	DONDERDAG	VRYDAG
07:30-08:15	**Ontbyt**	**Ontbyt**	**Ontbyt**	**Ontbyt**	**Ontbyt**
08:30-09:30		**SELFBEELD** Arbeidsterapeut	**SELFHANDHAWING (KONFLIKHANTERING)** Arbeidsterapeut	**HANTERING VAN MY STRES** Arbeidsterapeut	**TERAPEUTIESE AKTIWITEITS-GROEP**
09:30-10:30	**HOE MY SINTUIE MY BEïNVLOED** Arbeidsterapeut	**REFLEKTERING: SELFBEELD** Arbeidsterapeut	**TOEPASSING VAN VAARDIGHEDE** Arbeidsterapeut	**PERSOONLIKE PLAN** Arbeidsterapeut	Arbeidsterapeut
10:30-10:45	**TEE**	**TEE**	**TEE**	**TEE**	**TEE**
10:45-11:45	**GEïNTEGREERDE BEWEGING** Sielkundige	**DIE PSIGE VAN DIE MENS II** Sielkundige	**PERSOONLIKHEIDSTIPES EN VERHOUDINGS** Sielkundige	**TERAPEUTIESE AKTIWITEITS-GROEP**	
11:45-12:45	**SEKSUALITEIT** Sielkundige	**WEN JOU HOOFPYN** Fisioterapeut	**HANTERING VAN MY ANGS** Arbeidsterapeut	Arbeidsterapeut	
12:45-14:15	**ETE**	**ETE**	**ETE**	**ETE**	**ETE**
14:15-15:15	**STRES EN MY PERSOONLIKHEID** Arbeidsterapeut	**ONTSPANNINGSTERAPIE** Arbeidsterapeut	**ONTSPANNINGSTERAPIE** Arbeidsterapeut	**PADKOS** Psigiater	
15:15-16:15	**TERAPEUTIESE AKTIWITEITS-GROEP** Arbeidsterapeut	**TERAPEUTIESE AKTIWITEITS-GROEP** Arbeidsterapeut	**TERAPEUTIESE AKTIWITEITS-GROEP** Arbeidsterapeut		
16:30-17:30	**ETE**	**ETE**	**ETE**	**ETE**	**ETE**

*An English psycho-social group program will be made available on request

Addendum B: Information and consent document: Stakeholders

UNIVERSITY OF THE FREE STATE
UNIVERSITEIT VAN DIE VRYSTAAT
YUNIVESITHI YA FREISTATA

UFS·UV
HEALTH SCIENCES
GESONDHEIDSWETENSKAPPE

Departement Arbeidsterapie
CR de Wet Gebou
Universiteit van die Vrystaat
Bloemfontein, 9300
Julie-Sept 2013

Geagte…… (naam van potensiële deelnemende kliënt)

ARBEIDSTERAPIE NAVORSINGSTUDIE

U word hiermee uitgenooi om deel te neem aan 'n navorsingstudie, as deel van my Meestersgraad in Arbeidsterapie aan die Universiteit van die Vrystaat, wat in die kliniek uitgevoer gaan word.

Hierdie dokument bevat kerninligting in verband met die studie; meer volledige inligting is by myself verkrygbaar.

DOEL VAN DIE STUDIE

Die doel van die studie is om die huidige arbeidsterapie lewensvaardighede program, my fasilitering daarvan en eksterne faktore wat dit beïnvloed, te ondersoek, ten einde insig te verkry, en indien nodig, veranderinge aan te bring, sodat ek die beste moontlike diens aan my kliënte verskaf.

Die resultate van die studie mag dus lei tot moontlike veranderinge in die huidige arbeidsterapieprogram en my fasilitering daarvan, asook waar moontlik, eksterne faktore wat dit beïnvloed, ten einde die kwaliteit van intervensie te verbeter.

TOESTEMMING VIR DIE UITVOER VAN DIE STUDIE

Die studie is goedgekeur deur die Etiekkomitee van die Universiteit van die Vrystaat (ECUFSW136/2013).

NAVORSINGSPROSEDURE

Deelname van 'n deelnemer behels die volgende:

- Om 'n kort vraelys te voltooi voor die aanvang van die arbeidsterapie lewensvaardigheidsgroe program (dit sal tydens oriëntasie of in die klint se vrye tyd gedoen word).

- Om 'n paar vrae op 'n refleksienota te beantwoord na afloop van elke individuele arbeidsterapie lewensvaardigheidsgroep.

- Om 'n vraelys te voltooi na die beëindiging van die twee-week arbeidsterapie lewensvaardigheidsgroepprogram (dit sal tydens die laaste groep of tydens die kliënt se vryetyd gedoen word).

Deelname aan die studie sal nie inmeng met u deelname aan die groepsprogram of individuele terapiesessies/afsprake met u dokter of sielkundige nie.

POPULASIE BETROKKE IN STUDIE

Alle kliënte in die kliniek wat die navorser se Afrikaanse lewensvaardigheidsgroepe binne die aangewysde twee-week periode bywoon, sal uitgenooi word om aan die studie deel te neem.

RISIKO EN ONGERIEFLIKHEIDSFAKTORE

Daar is geen bekende risiko of ongerieflikheidsfaktore wat met die studie geassosieer word nie. Deelname is vrywillig.

VOORDELE

Hierdie studie mag moontlik nie voordele vir die kliënt in die korttermyn inhou nie, maar mag veranderinge en moontlike verbeterde kwaliteit van intervensie deur die navorser, in terme van die huidige arbeidsterapie lewensvaardigheid program tot gevolg hê.

ALTERNATIEF TOT DEELNAME

Indien u verkies om nie aan die studie deel te neem nie, sal daar op geen wyse teen u gediskrimineer word of u sleg behandel word tydens u opname in die kliniek nie. U sal ook nie deur die navorser anders as ander kliënte behandel word of teen gediskrimineer word in die arbeidsterapie lewensvaardigheidsgroepe nie.

VERGOEDING EN KOSTES (aan en van deelnemers)

Vergoeding

Geen vergoeding sal aan deelnemers aangebied word vir deelname aan die studie nie.

Koste

Die koste van die studie is die verantwoordelikheid van die navorser en geen kostes sal deur die deelnemers betaal hoef te word nie.

ONTREKKING VAN DIE STUDIE

Deelname is vrywillig en u is welkom om enige tyd tydens die studie te onttrek sonder enige vooroordeel van die navorser.

VERTROULIKHEID

- Die identiteit van alle deelnemers sal vertroulik hanteer word.
- Inligting wat tydens die studie ingesamel is sal ook vertroulik hanteer word. Onder geen omstandighede sal 'n deelnemer se naam deur die navorser bekend gemaak word nie.
- Inligting wat anoniem voorkom sal ook nie so aan die publiek bekend gemaak word dat 'n deelnemer deur lede van die publiek geïdentifiseer kan word nie.
- Data wat deur die navorser ingesamel is, sal slegs aan die navorser self, die ko-kodeerders, studieleiers en biostatistikus by die Universiteit van die Vrystaat bekend gemaak word. Die genoemde persone word ook gebind deur dieselfde riglyne oor konfidensialiteit as die navorser en sal die inligting op 'n hoogs professionele en konfidensiële manier hanteer.
- Ten einde die kliniek teen onregverdige en oningeligte kritiek te beskerm, sal die naam van die kliniek nie in enige publikasies voorkom nie.
- Die kliniek, die arbeidsterapie praktyk, multi-dissiplinêre spanlede, die psigo-sosiale groepsterapieprogram of arbeidsterapie lewensvaardigheidgroepe, sal op geen punt tydens die studie in 'n slegte lig gestel word deur te impliseer dat die program, diens of fasiliteit nie op standaard of on bevoeg is nie.
- Die navorser kan moontlik die resultate in 'n geakkrediteerde joernaal publiseer of die navorsingstudie by 'n kongres of arbeidsterapie vergadering/samekoms voordra. Geen persoonlike inligting van deelnemers sal aan die publiek bekend gemaak word nie.

Dankie.

Esna Carroll
Arbeidsterapeut
esna_carroll@yahoo.com
B. Occ. (UFS; 2003)
Tel: 082 676 1581

Dr R Van Heerden
Studieleier
Senior lektor
Dept. ABT, UV
Tel: 051 401 2829

Dr S Du Toit
Mede studieleier
Senior lektor
Dept. ABT, UV
Tel: 051 401 2829

Ek bevestig hiermee dat ek die bogenoemde dokument gelees het. Ek verstaan die implikasies van deelname aan die studie.

Ek, ……, gee hiermee my toestemming vir deelname aan die navorsingstudie, soos deur die navorser uitgevoer, vir die redes soos in die bogenoemde dokument beskryf.

…… …….
Deelnemer handtekening Datum

Ek het die studie aan die deelnemer verduidelik soos bo beskryf, ten einde kennis te bevorder, sodat 'n ingeligte besluit tot deelname deur die deelnemer geneem kon word.

…… ……
Navorser handtekening Datum

Addendum C: Letter of permission to management; the PC

UNIVERSITY OF THE FREE STATE
UNIVERSITEIT VAN DIE VRYSTAAT
YUNIVESITHI YA FREISTATA

UFS·UV
HEALTH SCIENCES
GESONDHEIDSWETENSKAPPE

Dept of Occupational Therapy
CR de Wet Building
University of the Free State
Bloemfontein, 9300
July–September 2013

Dear …….

OCCUPATIONAL THERAPY RESEARCH PROJECT AT THE CLINIC

I am hereby writing to obtain your consent to conduct a research study at the clinic in fulfillment of the requirements for a Magister Degree in Occupational Therapy at the UFS.

Researcher

Ms Esna Carroll, occupational therapist
B. Occ. (UFS; 2003), HPCSA no: OT 0060127.

I am an occupational therapist working at a private occupational therapy practice and a presenter of life skill groups within the psycho-social group program at the clinic.

Observations I made during the presentation of sessions, conversations with colleagues, and feedback from clients, lead me to reflect on my own facilitation of group therapy. In addition, clients who were re-admitted, and whom already completed the two week program, reported still having problems in terms of 'life skills'. Reflecting on my own practice, I thus had to answer the unyielding question if I was attaining 'best practice' with my presentation of life skill groups and if any changes could be made to better these groups.

I have therefor decided to direct my research project toward exploring the current occupational therapy life skill program, my facilitation thereof and external factors influencing the groups. The intention is to gain insight, to incorporate changes (if necessary and where possible) to ensure best client-centred practice within the context at the clinic.

The results of this study may thus lead to changes being made to the researchers' life skill groups, to ensure improved quality of intervention according to information obtained during the study.

With regards to the impact of this study on the clients at the clinic, I want to assure you that it is my intent to conduct the study in such a way that it would not in any way influence the group program, meal times and doctors' and psychologists' appointments. I will inform management of the commencement of each 2 week cycle (I am aiming to include 3 of these 2 week cycles in my study).

The nature of participation to the study is voluntary, and entails the completion of a short questionnaire before and after the 2 week cycle, and filling out a brief reflection form after each life skill group (or in a client's free time).

This document further includes core information; and more detail is available from the researcher.

PURPOSE OF THE STUDY

The purpose of the study is to explore the current occupational therapy life skill program, my facilitation thereof and external factors influencing the groups. The intention is to gain insight, to incorporate changes (if necessary and where possible) to ensure best client-centred practice within the context at the clinic.

APPROVAL OF THE STUDY

The study has been approved by the Ethics Committee of the University of the Free State (UFS) (ECUFSW136/2013).

RESEARCH PROCEDURES

The following will be asked of the study participants

- To fill out a short questionnaire before the commencement of the group program (this will be done at the orientation session or in the clients free time).
- To answer questions on a reflection note after the completion of each individual life skill group or in the clients free time.
- To fill out a questionnaire after the completion of the two week life skill program (this will be done after completion of the last life skill group or in the clients free time).

Participation in the study will not interfere with the group program OR individual appointments with doctors or psychologists.

POPULATION INVOLVED

All client's attending the researcher's Afrikaans group therapy program within the allocated two week presentation period at the Clinic, will be invited to participate in this study.

RISKS AND DISCOMFORTS

There are no known risks and/or discomforts associated with the procedures described in this study. Participation is voluntary.

BENEFITS

This study may not benefit the participant in the short term, but may lead to alteration and improved quality of intervention of the researcher's life skill groups. This in turn may benefit other people admitted to the Clinic in the future.

ALTERNATIVES TO PARTICIPATION

Choosing not to participate, will not in any way lead to discrimination or ill-treatment during the client's stay at the Clinic, or to the client being treated differently by the researcher within the life skill groups.

COMPENSATION, COSTS AND REIMBURSEMENT (to participants)

Compensation or reimbursement

No reimbursement will be offered to participants.

Costs

Costs are covered by the researcher, and no costs will be incurred by participants.

WITHDRAWAL OR TERMINATION FROM THE STUDY

Participation is voluntary and participants are free to withdraw from this study at any time without penalty or prejudice.

CONFIDENTIALITY

- The identity of all participants will be treated confidentially.
- Information obtained during the study, will be handled confidentially. In no way will a participant's name be made public by the researcher, or will seemingly anonymous information on a participant be described in such a way that members of the public will be able to identify the person.
- Data obtained by the researcher, will be accessed by the researcher, co-coders, the study leaders and biostatistician at the University of the Free State. They are subject to the same codes of confidentiality as the researcher and will handle information in a highly confidential manner.
- The name of the clinic will not occur in any publications, in order to protect the clinic from unfair and uninformed criticism.
- The clinic, the occupational therapy practice in question, multidisciplinary team members and the group program will not be put in a bad light at any point during the study by implying that the program, service or facility is not proficient.
- The researcher may publish the results via an accredited journal or present the study at a congress or Occupational Therapy gathering/meeting. No personal information will be made public in these.

Thank you.

Esna Carroll
Occupational Therapist
esna_carroll@yahoo.com
Tel: 082 676 1581

Consent from management for an occupational therapy research study at the clinic

I, ……, hereby provide consent for the conduction of a research study by Ms Esna Carroll, at the clinic, in association with a private occupational therapy practice.

I have received relevant information regarding the procedures of the study, and understand the possible benefits thereof.

I understand that the referring psychiatrists and all stakeholders of the group therapy program will also receive this information document.

Signed: …… Date: ……

Addendum D: Letter of permission to the owner of the Occupational Therapy Private Practice

UNIVERSITY OF THE FREE STATE
UNIVERSITEIT VAN DIE VRYSTAAT
YUNIVESITHI YA FREISTATA

UFS·UV
HEALTH SCIENCES
GESONDHEIDSWETENSKAPPE

Dept. of Occupational Therapy
CR de Wet Building
University of the Free State
Bloemfontein, 9300
July–September 2013

Dear .....

OCCUPATIONAL THERAPY RESEARCH PROJECT AT THE CLINIC

I am hereby writing to obtain your consent to conduct a research study at the clinic in fulfillment of the requirements for a Magister Degree in Occupational Therapy at the UFS.

Researcher

Ms Esna Carroll, occupational therapist
B. Occ. (UFS; 2003), HPCSA nr: OT 0060127

Observations I made during the presentation of sessions, conversations with colleagues, and feedback from clients, lead me to reflect on my own facilitation of group therapy. In addition, clients who were re-admitted, and whom already completed the two week program, reported still having problems in terms of 'life skills'. Reflecting on my own practice I thus had to answer the unyielding question if I was attaining 'best practice' with my presentation of life skill groups and if any changes could be made to better these groups.

I have therefor decided to direct my research project toward exploring the current occupational therapy life skill program, my facilitation thereof and external factors influencing the groups in order to gain insight, with the intention of (if necessary and where possible) incorporate changes to ensure best client-centred practice within the context at the Clinic.

The results of this study may thus lead to changes being made to the researchers' life skill groups, to ensure improved quality of intervention according to information obtained during the study.

With regards to the impact of this study on the clients at the clinic, I want to assure you that it is my intent to conduct the study in such a way that it would not in any way influence the group program, meal times and doctors' and psychologists' appointments. I will inform management

of the commencement of each 2 week cycle (I am aiming to include 3 of these 2 week cycles in my study).

The nature of participation to the study is voluntary, and entails the completion of a short questionnaire before and after the 2 week cycle and filling out a brief reflection form after each life skill group (or in a client's free time).

This document further includes core information; and more detail is available from the researcher.

PURPOSE OF THE STUDY

The purpose of the study is to explore the current occupational therapy life skill program, my facilitation thereof and external factors influencing the groups. The intention is to gain insight, to incorporate changes (if necessary and where possible) to ensure best client-centred practice within the context at the clinic.

APPROVAL OF THE STUDY

The study has been approved by the Ethics Committee of the University of the Free State (UFS) (ECUFSW136/2013).

RESEARCH PROCEDURES

The following will be asked of the study participants

- To fill out a short questionnaire before the commencement of the group program (this will be done at the orientation session or in the clients free time).
- To answer questions on a reflection note after the completion of each individual life skill group or in the clients free time.
- To fill out a questionnaire after the completion of the two week life skill program (this will be done after completion of the last life skill group or in the clients free time).

Participation in the study will not interfere with the group program OR individual appointments with doctors or psychologists.

POPULATION INVOLVED

All clients attending the researcher's Afrikaans group therapy program within the allocated two week presentation period at the Clinic, will be invited to participate in this study.

RISKS AND DISCOMFORTS

There are no known risks and/or discomforts associated with the procedures described in this study. Participation is voluntary.

BENEFITS

This study may not benefit the participant in the short term, but may lead to alteration and improved quality of intervention of the researcher's life skill groups. This in turn may benefit other people admitted to the Clinic in the future.

ALTERNATIVES TO PARTICIPATION

Choosing not to participate, will not in any way lead to discrimination or ill-treatment during the clients stay at the Clinic or to the client being treated differently by the researcher within the life skill groups.

COMPENSATION, COSTS AND REIMBURSEMENT (to participants)

Compensation or reimbursement

No reimbursement will be offered to participants.

Costs

Costs are covered by the researcher, and no costs will be incurred by participants.

WITHDRAWAL OR TERMINATION FROM THE STUDY

Participation is voluntary and participants are free to withdraw from this study at any time without penalty or prejudice.

CONFIDENTIALITY

- The identity of all participants will be treated confidentially.
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- They are subject to the same codes of confidentiality as the researcher and will handle information in a highly confidential manner.

- The name of the clinic will not occur in any publications, in order to protect the clinic from unfair and uninformed criticism.
- The clinic, the occupational therapy practice in question, multidisciplinary team members and the group program will not be put in a bad light at any point during the study by implying that the program, service or facility is not proficient.
- The researcher may publish the results via an accredited journal or present the study at a congress or Occupational Therapy gathering/meeting. No personal information will be made public in these.

Thank you.

Esna Carroll
Occupational Therapist
esna_carroll@yahoo.com
Tel: 082 676 1581

Consent for an occupational therapy research study at the clinic

I, ……, hereby provide consent for the conduction of a research study by Ms Esna Carroll, at the clinic, in association with a private occupational therapy practice.

I have received relevant information regarding the procedures of the study, and understand the possible benefits thereof.

I understand that the referring psychiatrists and all stakeholders of the group therapy program have received this same letter and information document.

Signed: …… Date: ……

Addendum E: Information letter to psychiatrists and multi-disciplinary team members

UNIVERSITY OF THE FREE STATE
UNIVERSITEIT VAN DIE VRYSTAAT
YUNIVESITHI YA FREISTATA

UFS·UV
HEALTH SCIENCES
GESONDHEIDSWETENSKAPPE

Dept. of Occupational Therapy
CR de Wet Building
University of the Free State
Bloemfontein, 9300
July–September 2013

Dear……

OCCUPATIONAL THERAPY RESEARCH PROJECT AT THE CLINIC

I am hereby writing to you to inform you and present you with information regarding a research study I am conducting at the clinic in fulfillment of the requirements for a Magister Degree in Occupational Therapy at the UFS.

Researcher

Ms Esna Carroll, occupational therapist
B. Occ. (UFS; 2003), HPCSA nr: OT 0060127.

I am an occupational therapist working at a private occupational therapy practice and a presenter of life skill groups within the psycho-social group program at the clinic.

Observations I made during the presentation of sessions, conversations with colleagues, and feedback from clients, lead me to reflect on my own facilitation of group therapy. In addition, clients who were re-admitted, and whom already completed the two week program, reported still having problems in terms of 'life skills'. Reflecting on my own practice I thus had to answer the unyielding question if I was attaining 'best practice' with my presentation of life skill groups and if any changes could be made to better these groups.

I have therefor decided to direct my research project toward exploring the current occupational therapy life skill program, my facilitation thereof and external factors influencing the groups. The intention is to gain insight, to incorporate changes (if necessary and where possible) to ensure best client-centred practice within the context at the clinic.

The results of this study may thus lead to changes being made to the researchers' life skill groups, to ensure improved quality of intervention according to information obtained during the study.

With regards to the impact of this study on the clients at the clinic, I want to assure you that it is my intent to conduct the study in such a way that it would not in any way influence the group program, meal times and doctors' and psychologists' appointments. I will inform management of the commencement of each 2 week cycle (I am aiming to include 3 of these 2 week cycles in my study).

The nature of participation to the study is voluntary, and entails the completion of a short questionnaire before and after the 2 week cycle and filling out a brief reflection form after each life skill group (or in a client's free time).

This document further includes core information; and more detail is available from the researcher.

PURPOSE OF THE STUDY

The purpose of the study is to explore the current occupational therapy life skill program, my facilitation thereof and external factors influencing the groups. The intention is to gain insight, to incorporate changes (if necessary and where possible) to ensure best client-centred practice within the context at the clinic.

APPROVAL OF THE STUDY

The study has been approved by the Ethics Committee of the University of the Free State (UFS) (ECUFSW136/2013).

RESEARCH PROCEDURES

The following will be asked of the study participants:

- To fill out a short questionnaire before the commencement of the group program (this will be done at the orientation session or in the clients free time).
- To answer questions on a reflection note after the completion of each individual life skill group or in the clients free time.
- To fill out a questionnaire after the completion of the two week life skill program (this will be done after completion of the last life skill group or in the clients free time).

Participation in the study will not interfere with the group program OR individual appointments with doctors or psychologists.

POPULATION INVOLVED

All clients attending the researcher's Afrikaans group therapy program within the allocated two week presentation period at the Clinic, will be invited to participate in this study.

RISKS AND DISCOMFORTS

There are no known risks and/or discomforts associated with the procedures described in this study. Participation is voluntary.

BENEFITS

This study may not benefit the participant in the short term, but may lead to alteration and improved quality of intervention of the researcher's life skill groups. This in turn may benefit other people admitted to the Clinic in the future.

ALTERNATIVES TO PARTICIPATION

Choosing not to participate, will not in any way lead to discrimination or ill-treatment during the clients stay at the Clinic or to the client being treated differently by the researcher within the life skill groups.

COMPENSATION, COSTS AND REIMBURSEMENT (to participants)

Compensation or reimbursement

No reimbursement will be offered to participants.

Costs

Costs are covered by the researcher, and no costs will be incurred by participants.

WITHDRAWAL OR TERMINATION FROM THE STUDY

Participation is voluntary and participants are free to withdraw from this study at any time without penalty or prejudice.

CONFIDENTIALITY

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- Information obtained during the study, will be handled confidentially. In no way will a participant's name be made public by the researcher; or will seemingly anonymous

information on a participant be described in such a way that members of the public will be able to identify the person.

- Data obtained by the researcher, will be accessed by the researcher, co-coders, the study leaders and biostatistician at the University of the Free State. They are subject to the same codes of confidentiality as the researcher and will handle information in a highly confidential manner.
- The name of the clinic will not occur in any publications, in order to protect the clinic from unfair and uninformed criticism.
- The clinic, the occupational therapy practice in question, multidisciplinary team members and the group program will not be put in a bad light at any point during the study by implying that the program, service or facility is not proficient.
- The researcher may publish the results via an accredited journal or present the study at a congress or Occupational Therapy gathering/meeting. No personal information will be made public in these.

Please contact me with any questions or concerns.

Thank you.

Esna Carroll
Occupational Therapist
esna_carroll@yahoo.com
Tel: 082 676 1581

Addendum F: Eerste vraelys (First questionnaire)

VIR KANTOOR GEBRUIK

Datum: .....

Siklus: .....

Nommer: ..... Voltooi: Tydens groep/In eie tyd (omkring)

1. Wat is jou geslag?

1	Manlik
2	Vroulik

2. Hoe oud is jy? ..... Jaar.

3. Wat is jou hoogste kwalifikasie/vlak van opleiding?

.....

4. Watter werk doen jy?

.....

5. Waar woon jy tans (naam van dorp/stad)?

.....

6.1	Ek is depressief.	
6.2	Ek is angstig.	
6.3	Ek is uitgebrand.	
6.4	My dokter wil my medikasie uitsorteer.	
6.5	Ek is deur 'n traumatiese ervaring.	
6.6	Ek het iemand na aan my aan die dood afgestaan.	
6.7	Ek is besig met/of is deur 'n egskeiding.	
6.8	Ek het 'n verslawing (drank, pille, dwelms ens.)	
6.9	Ek ervaar chroniese pyn.	
6.10	Ek het 'n fisiese siekte.	
6.11	Ek is die versorger van 'n afhanklike persoon.	
6.12	Ek beleef baie spanning by die werk.	

6.13	Ek beleef baie spanning in my verhouding(s).	
6.14	Ek sien nie meer kans vir die lewe nie.	
6.15	Ek weet nie. Ek is gedwing om hier te wees.	
6.16	Sodat ek gespesialiseerde toetse (bv. EEG) kan ondergaan	
6.17	Ander: (spesifiseer)	

Siklus:	Nommer:

Addendum G: Refleksie Siklus 1 (Reflection Cycle 1)

VIR KANTOOR GEBRUIK	
Datum:	
Siklus:	
Tema:	
Nommer:	Voltooi: Tydens groep/In eie tyd (omkring)

1. Was die tema van hierdie sessie relevant vir jou?

1	Ja
2	Nee

3. Wat van die sessie was vir jou positief?

4. Wat van die sessie was vir jou negatief?

	Faktore	
7.1	Ek het angstig, onsteld of depressief gevoel.	
7.2	Die newe-effekte van my medikasie.	
7.3	Ek voel nie gemotiveerd ("committed") om aan die groepe deel te neem nie.	
7.4	Ek het nie voor die aanvang van groepe die geleentheid gehad om individueel met die terapeut te gesels nie.	
7.5	Die tydsgleuf van die groep (tyd van die dag).	
7.6	Die vaste program, die feit dat arbeidsterapiegroepe nie altyd op mekaar volg nie.	
7.7	Die onderbreking van groepe wanneer 'n mede-groepslid gesoek word vir 'n afspraak by 'n ander spanlid.	
7.8	Ek kon nie die groep bywoon nie of het net 'n gedeelte bygewoon agv ander afsprake.	
7.9	My fisiese toestand (siekte/pyn)	

7.10	Ek is bekommerd oor iets buite die groep (ek dink voortdurend aan goed wat my pla).	
7.11	Ek voel nie gemaklik binne 'n groepsopset nie	
7.12	Ek vind nie aanklank met die aanbieder nie.	
7.13	Ek sukkel om te fokus of te konsentreer.	
7.14	'n Ander groepslid wat baie praat, die groep oorneem, ontoepaslik optree ens.	
7.15	Ek woon net groepe by omdat my dokter my verplig.	
7.16	Ek dink nie ek hoef hier te wees nie.	
7.17	Ek het nie gister aand geslaap nie/sleg geslaap of moes wakker bly vir 'n EEG.	
7.18	Ek is omgekrap deur iets wat in die hierdie groep of vorige groep bespreek is of deur 'n telefoon oproep/my sielkundige/my psigiater.	
7.19	Ander: (spesifiseer)	

8. Dui aan watter van die volgende faktore het 'n positiewe invloed op jou ervaring van die groep gehad of bygedra het om by die groep te baat

	Faktore	
8.1	My gemoed voel beter.	
8.2	Ek het nie newe-effekte van die medikasie nie, my medikasie werk.	
8.3	Ek voel gemotiveerd ("committed") om aan die groepe deel te neem nie.	
8.4	Ek het voor die aanvang van groepe die geleentheid gehad om individueel met die terapeut te gesels.	
8.5	Die tydsgleuf van die groep (tyd van die dag).	

8.6	Die vaste program, die feit dat arbeidsterapie groepe nie altyd op mekaar volg nie.	
8.7	My fisiese toestand.	
8.8	Ek voel gemaklike binne die groepsopset.	
8.9	Ek vind aanklank met die aanbieder.	
8.10	Ek fokus en konsentreer vandag goed.	
8.11	Ek het gisteraand goed geslaap.	
8.12	Ek kon identifiseer met een van die ander lede in die groep.	
8.13	Ek kon identifiseer met voorbeelde wat in die groep gebruik is.	
8.14	Ek voel veilig in die groep, ek voel ek behoort.	
8.15	Ek besef dat ander mense ook swaar in die lewe het.	
8.16	Ek het nuttige inligting ontvang.	
8.17	Ek het vir iemand anders in die groep iets beteken.	
8.18	Ek kan sê hoe ek voel in die groep en voel daarna verlig.	
8.19	Ek leer myself beter ken.	
8.20	Ek het iets by 'n ander groepslid geleer.	
8.21	Ek kan met die ander groepslede sosialiseer en voel nie alleen nie.	
8.22	Ander: (spesifiseer)	

Addendum H: Laaste vraelys Siklus 1 en 2 (Last questionnaire Cycle 1 and 2)

VIR KANTOOR GEBRUIK
Datum: .....
Siklus: .....
Tema: .....
Voltooi: Tydens groep/In eie tyd
Nommer: (omkring)

	Vraag	**Definitief**	**In 'n mate**	**Glad nie**
1.1	Het jou kennis omtrent stres verbeter?			
1.2	Verstaan jy jou eie stres? (oorsake, simptome en quick fixes)			
1.3	Voel jy gemotiveerd om streshanteringsteg-nieke in die toekoms toe te pas?			

1.4 Watter veranderinge gaan jy implimenteer om jou stres beter in die toekoms te hanteer? In watter situasie is dit op jou van toepassing?

.....

.....

.....

	Vraag	**Definitief**	**In 'n mate**	**Glad nie**
2.1	Het jy kennis opgedoen oor angs?			
2.2	Verstaan jy jou eie angs nou beter?			
2.3	Voel jy bereid om jou angs in die toekoms anders te probeer hanteer, na aanleiding van die riglyne wat bespreek is?			

2.4 Hoe gaan jy jou angs in die toekoms beter hanteer? In watter situasie is dit op jou van toepassing?

.....

Siklus: Nommer:

	Vraag	**Definitief**	**In 'n mate**	**Glad nie**
3.1	Verstaan jy wat selfbeeld is en hoe dit jou gedrag beinvloed?			
3.2	Het jy nou kennis omtrent jou sterkpunte en swakpunte?			
3.3	Het jy 'n ander/ nuwe siening van jouself?			

3.4 Hoe gaan jy hierdie ander/nuwe siening van jouself in die toekoms uitleef? In watter situasie is dit op jou van toepassing?

.....

	Vraag	**Definitief**	**In 'n mate**	**Glad nie**
4.1	Het jy jouself beter leer ken?			
4.2	Is jy nou meer bewus van jou eie behoeftes en verwagtings?			

4.3 Noem een manier en in watter situasie jy jou selfkennis kan aanwend om 'n aspek van jou lewe beter te maak?

.....

.....

	Vraag	**Definitief**	**In 'n mate**	**Glad nie**
5.1	Voel jy dat jy genoegsaam toegerus is (dus die nodige kennis het) om in die toekoms beter te kommunikeer?			
5.2	Is jy bewus van hoe jy normaalweg kommunikeer en kommunikasiefoute wat jy begaan?			
5.3	Is jy gemotiveer om dit wat jy van kommunikasie geleer het, in die toekoms uit te toets tot jy iets kry wat vir jou werk?			

Siklus:	Nommer:

5.4 Op watter maniere en in watter situasie kan jy in die toekoms beter kommunikeer?

.....

	Vraag	**Definitief**	**In 'n mate**	**Glad nie**
6.1	Weet jy wat selfhandhawing is?			
6.2	Verstaan jy hoe jy gewoonlik jouself handhaaf?			
6.3	Dink jy jy gaan probeer om in die toekoms meer selfhandhawend te wees? Is jy bereid om van die selfhandhawingstegnieke in die toekoms te gaan toepas?			

6.4 Watter selfhandhawingstegnieke dink jy kan vir jou in die toekoms werk ten einde meer selfhandhawend te wees? In watter situasie sal jy dit gebruik?

.....

.....

.....

	Vraag	**Definitief**	**In 'n mate**	**Glad nie**
7.1	Verstaan jy hoe jy gewoonlik in 'n konflik situasie optree?			
7.2	Weet jy wat om te doen sodat jou konflik 'n beter resultaat tot gevolg het?			
7.3	Gaan jy probeer om jou konflik anders in die toekoms te hanteer?			

Siklus:	Nommer:

8. Dui aan oor watter van die onderstaande temas jy meer kennis sal wil hê en verduidelik hoekom (bv. ek kon nie al die sessies oor die tema bywoon nie, of daar is nie genoeg inligting deurgegee nie, ens.)

	Tema	**x**	**Rede**
8.1	Stres		
8.2	Angs		
8.3	Selfbeeld		
8.4	Selfkennis		
8.5	Selfhandhawing		
8.6	Kommunikasie		
8.7	Konflik		
8.8	Dagbeplanning		
8.9	Probleemoplossing		
8.10	Persoonlike waardes		
8.11	"Anger management"		
8.12	Emosies		
8.13	Ander		

9. Merk die onderstaande vraelys deur "ja", "in 'n mate" of "nee" by elke vraag aan te dui.

	Vraag	**Ja**	**In `n mate**	**Nee**
9.1	Het jy met aanvang van die program genoegsame inligting gehad om die besluit te kon neem om arbeidsterapiegroepe by te woon?			
9.2	Het dit vir jou gevoel of jy self die keuse gemaak het om arbeidsterapiegroepe by te woon.			
9.3	Het dit vir jou gevoel dat jy die geleentheid gegee is om verantwoordelikheid vir jouself tydens arbeidsterapiegroepe te neem?			
9.4	Was die arbeidsterapeut in `n rol waar sy jou lei en die proses fasiliteer eerder as om voor te skryf.			
9.5	Het dit vir jou gevoel of jy die geleentheid gehad om self jou eie "life skill" doelwitte te identifiseer.			
9.6	Het jy jou eie "life skills" doelwitte bereik? (Indien dit nie moontlik is om in die hospitaal te bereik nie, is jy gemotiveerd om dit by die huis na te streef?)			
9.7	Het die arbeidsterapeut jou gelei en bemagtig om jou doelwitte te bereik?			
9.8	Dink jy die arbeidsterapeut het jou unieke situasie, rolle wat jy inneem ens verstaan en dit tydens groepe in ag geneem?			
9.9	Was die arbeidsterapiegroepe toeganklik, prakties maklik om by te woon?			
9.10	Is daar aan jou behoeftes voldoen tydens die arbeidsterapie groepe?			
9.11	Het jy ervaar dat die arbeidsterapeut jou siening, opinies, waardes en doelwitte respekteer?			
9.12	Is jou gesindheid teenoor arbeidsterapie groepe tans positief?			
9.13	Voel jy dat `n bevredigende diens gelewer is met die aanbieding van die arbeidsterapiegroepe?			
9.14	Voel jy dat die arbeidsterapiegroepe bygedra het om jou toe te rus tot beter lewenskwaliteit?			
9.15	Dink jy arbeidsterapiegroepe het `n positiewe rol gespeel in jou helingsproses?			
9.16	Sal jy iemand anders aanbeveel om die arbeidsterapie lewensvaardigheidsgroepe by te woon?			

Addendum I: Refleksie Siklus 2 (Reflection Cycle 2)

VIR KANTOOR GEBRUIK	
Datum:	
Siklus:	
Tema:	
Nommer:	Voltooi: Tydens groep / In eie tyd (omkring)

1. Was die tema van die arbeidsterapiesessies relevant vir jou?

1	Ja
2	Nee

3. Dit was vir my positief/goed dat…

4. Dit was vir my negatief/sleg dat…….

	Faktore	
7.1	Ek het angstig, onsteld of depressief gevoel.	
7.2	Die newe-effekte van my medikasie.	
7.3	Ek voel nie gemotiveerd ("committed") om aan die groepe deel te neem nie.	
7.4	Ek het nie voor die aanvang van groepe die geleentheid gehad om individueel met die terapeut te gesels nie.	
7.5	Die tydsgleuf van die groep (tyd van die dag).	
7.6	Die vaste program, die feit dat arbeidsterapie groepe nie altyd op mekaar volg nie.	
7.7	Die onderbreking van groepe wanneer 'n mede-groepslid gesoek word vir 'n afspraak by 'n ander spanlid.	
7.8	Ek kon nie die groep bywoon nie of het net 'n gedeelte bygewoon agv ander afsprake.	
7.9	My fisiese toestand (siekte/pyn)	

7.10	Ek is bekommerd oor iets buite die groep (ek dink voortdurend aan goed wat my pla).	
7.11	Ek voel nie gemaklik binne 'n groepsopset nie	
7.12	Ek vind nie aanklank met die aanbieder nie.	
7.13	Ek sukkel om te fokus of te konsentreer.	
7.14	'n Ander groepslid wat baie praat, die groep oorneem, ontoepaslik optree ens.	
7.15	Ek woon net groepe by omdat my dokter my verplig.	
7.16	Ek dink nie ek hoef hier te wees nie.	
7.17	Ek het nie gister aand geslaap nie/sleg geslaap of moes wakker bly vir 'n EEG.	
7.18	Ek is omgekrap deur iets wat in die hierdie groep of vorige groep bespreek is of deur 'n telefoon oproep/my sielkundige/my psigiater.	
7.19	Ek was fisies ongemaklik. (bv. stoele, "air-con", skerp lig)	
7.20	My aandag is afgetrek deur geluide van buite.	
7.21	Die breuke is te kort/te min.	
7.22	Ander: (spesifiseer)	

8. Dui aan watter van die volgende faktore het 'n positiewe invloed op jou ervaring van die arbeidsterapi sessies gehad of bygedra om jou by die sessies te laat baat

	Faktore	
8.1	My gemoed voel beter.	
8.2	Ek het nie newe effekte van die medikasie nie, my medikasie werk.	
8.3	Ek voel gemotiveerd ("committed") om aan die groepe deel te neem.	
8.4	Ek het voor die aanvang van groepe die geleentheid gehad om individueel met die terapeut te gesels.	
8.5	Die tydsgleuf van die groep (tyd van die dag).	

8.6	Die vaste program, die feit dat arbeidsterapiegroepe nie altyd op mekaar volg nie.	
8.7	My fisiese toestand.	
8.8	Ek voel gemaklike binne die groepsopset.	
8.9	Ek vind aanklank met die aanbieder.	
8.10	Ek fokus en konsentreer vandag goed.	
8.11	Ek het gisteraand goed geslaap.	
8.12	Ek kon identifiseer met een van die ander lede in die groep.	
8.13	Ek kon identifiseer met voorbeelde wat in die groep gebruik is.	
8.14	Ek voel veilig in die groep, ek voel ek behoort.	
8.15	Ek besef dat ander mense ook swaar in die lewe het.	
8.16	Ek het nuttige inligting ontvang.	
8.17	Ek het vir iemand anders in die groep iets beteken.	
8.18	Ek kan sê hoe ek voel in die groep en voel daarna verlig.	
8.19	Ek leer myself beter ken.	
8.20	Ek het iets by 'n ander groepslid geleer.	
8.21	Ek kan met die ander groepslede sosialiseer en voel nie alleen nie.	
8.22	Ander: (spesifiseer)	

Addendum J: Refleksie Siklus (Reflection Cycle 3)

VIR KANTOOR GEBRUIK	
Datum:	
Siklus:	
Tema:	
Nommer:	Voltooi: Tydens groep/In eie tyd (omkring)

1. Wat vat jy saam uit hierdie sessie?

.....

.....

2. Vandag se speletjie was:

.....

2.1 Dit was vir my:

Positief	Negatief

2.2 Dit het bygedra om die groep meer effektief/sinvol te maak:

Ja	Nee

2.3 Indien nee, hoekom nie?

.....

3. Notas in boek:

3.1 Dit was vir my:

Positief	Negatief

3.2 Dit het bygedra om die groep meer effektief/sinvol te maak:

Ja	Nee

3.3 Indien nee, hoekom nie?

.....

Addendum K: Steps taken to ensure an AR process directed data collection

Firstly written consent for the research project was obtained from the Management of the Psychiatric Clinic (PC) and the owner of the Occupational Therapy Practice. An information letter which included detailed information on the study, it's purpose, methods of data collection and planned outcomes were given to the above mentioned parties (Addendum C, D).

The protocol for the study was submitted to the ethics committee of the Faculty of Health Sciences of the University of the Free State for consideration. The Ethics Committee of the Faculty of Health Sciences of the University of the Free State gave consent towards the study.

After consent was obtained from the ethics committee the parties mentioned in (a) were informed by letter of the date of commencement of the first cycle of the research study and the commencement of the following cycles respectively.

Before the commencement of the study the matron of the PC and all referring doctors also received an information letter which included detailed information on the study, it's purpose, methods of data collection and planned outcomes. They could contact the researcher if they had concerns regarding the study (Addendum E).

The nature of AR included a preparation phase (equal to a pilot study) and the first (1st) AR cycle was used to "streamline" the research process and to gain confidence [with techniques used in AR] in measurement instruments compiled for the study (questionnaires) and to explore the research opportunities provided by an AR cycle. Here after adjustments were made before the commencement of the second (2nd) AR cycle.

Informed consent was then obtained from potential stakeholders (Addendum B) (subsequently becoming stakeholders) and they received an information letter which again included detailed information (as discussed previously during the information session). The letter gave information on the study its purpose and planned outcomes, method of data collection, publication of results and their rights as stakeholders as discussed above. Stakeholders had to understand that data were strictly confidential and that all information was to be handled confidentially.

During this "session" a questionnaire were given to potential stakeholders to complete (Addendum F). The questionnaire was distributed in the group while potential stakeholders were seated. It was taken in again by the researcher to be placed in a plastic A4 envelope in order to ensure that no questionnaires were lost. If a potential stakeholder could not attend this session for any reason, an information session, informed consent and the completion of the questionnaire were done individually with the potential stakeholder as soon as possible. It was indicated on the questionnaire whether the questionnaire was filled out in the group or in an individual session. A number were allocated to each stakeholder and all questionnaires and reflections were only marked by that number, questionnaires and reflections were thus kept confidential.

Stakeholders attended the occupational therapy groups of the researcher for the next two weeks. They were asked to complete a written reflection (Addendum G – cycle 1 and 2, Addendum I – cycle 3) on each session by means of a questionnaire (unattached page) with open-ended and closed ended questions. The reflections were handed out to each stakeholder by the researcher, while they were still seated. The reflection needed to be answered on completion of the session, or in their own time. Reflections were taken in by the researcher as participants left the group or the next day at the group and placed in a plastic A4 envelope to ensure that no questionnaires were lost. (It was indicated on the questionnaire whether the questionnaire was filled out in the group or in the stakeholders own time).

A second questionnaire (Addendum H) was handed out by the researcher to stakeholders. This was done after the last occupational therapy group presented to stakeholders on the Thursday of the second week of the program, while they were still seated to complete then or in their own time. Questionnaires were taken in by the researcher as participants left the group or the next day and placed in a plastic A4 envelope to ensure that no questionnaires were lost. As mentioned before it was indicated on the questionnaire whether the questionnaire was completed in the group or in the stakeholders own time.

The qualitative data obtained were coded, categorised and defined by the researcher and co-coders during and after the AR cycle (Table 3.11). The two co-coders included a colleague (OT) in the same practice with five (5) years' experience in the presentation of life skill groups, a Master's degree and experience in qualitative research and thematic coding. The other co-coder is also an OT and a lecturer at the dept. of Occupational therapy at the University of the Free State with experience in mental health, a Master's degree and knowledge on qualitative research.

Quantitative data obtained from completed questionnaires and reflections were entered into an EXCEL spread sheet by the researcher every evening during the cycle. The data was entered into EXCEL twice (on different spread sheets). These spread sheets (completed by the researcher) were then checked by one of the co-coders for correctness and consistency. After the first week of the AR cycle and again after the second week of the cycle the spread sheets were sent to the Dept. Biostatistics, UFS for analyses electronically. It was first verified and then analysed after all the data for a certain cycle have been received.

The data obtained were then according to the AR process used in the planning of the next AR cycle. A notation of planned changes or factors to be addressed was then made by the researcher.

The researcher repeated the above mentioned cycle three times according to the saturation obtained.