THE OCCUPATIONS AND SOCIO-CULTURAL CONTEXT OF SESOTHO SPEAKING ADULTS WITH MENTAL HEALTH PROBLEMS

by

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DECLARATION

I hereby declare that the dissertation entitled

'THE OCCUPATIONS AND SOCIO-CULTURAL CONTEXT

OF SESOTHO SPEAKING ADULTS WITH MENTAL HEALTH PROBLEMS',

handed in 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.

Mia Elsabie Vermaak

Misunderstanding occurs when we erroneously assume
that others view the world in the same way as we do.

(Turpin & Nelson 2007:323)

I dedicate this work to:

***Nadiha Visser**, born 26th April 2010.*

And to every person Living Life with her.

You remind me of the Joy and Hope awaiting us in Eternity.

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List of Acronyms

CMOP	Canadian Model of Occupational Performance
EBP	Evidence based practice
MHCF	Mental Health Care Facility
OT	Occupational therapy
OTPF	Occupational Therapy Practice Framework
SAPS	South African Police Service
UFS	University of the Free State, Bloemfontein, South Africa.
UK	The United Kingdom
USA	The United States of America
WHO	World Health Organization

Concept Clarification

Important concepts that will be used throughout this dissertation, are described as understood and used by the researcher throughout the study. Concepts are listed alphabetically.

Both Clinics

Refers to both The Clinic and The Second Clinic (see below).

Cultural competence

Cultural competence refers to the knowledge and awareness of, and sensitivity towards, the meaning of culture in patients and therapy (Creek & Lougher 2008:580).

Group therapy

Group therapy is a regularly used modality or therapeutic procedure in occupational therapy (OT), where patients receive treatment in group sessions. It has been proven as therapeutically effective (Howe & Schwartzberg 2001:1 & 248).

Kawa model

"The Kawa model attempts to explain occupational therapy's overall purpose, strategies for interpreting a client's circumstances and clarify the rational and application of occupational therapy within the client's particular social and cultural context" (Iwama 2006:139). The model uses the metaphor of a river to explore a person's life, including his/her problems, assets and liabilities, and support systems.

Life skills

Life skills are required to function with all aspects regarding everyday living, ranging from driving a vehicle to managing conflict in the work situation. Psychosocial life skills are a group of skills based on behaviour, cognition and social interaction. Affective and

anxiety disorders may be associated with life skill deficits, which become the focus of OT intervention in mental health facilities, in order to enable the patient to function at an optimal level (Roberts 2008:364-368).

Occupation, activity and task

The Department of Occupational Therapy, UFS; divides occupations into the following categories: work, play or education; recreation or leisure; activities of personal independence; social participation and sleep. Different tasks need to be done to complete an activity; while several activities are included within an occupation. During this study, the researcher will adopt this classification of occupation, activity and task, with occupation being the 'larger unit', consisting of clusters of activities, which are in turn made up of clusters of tasks (Creek & Lougher 2008:581).

For the present study, occupations will be classified as follows: work or education; recreation or leisure; activities of personal independence; social participation and sleep.

This explanation is supported by the following graphic example (Figure 1), designed by the researcher:

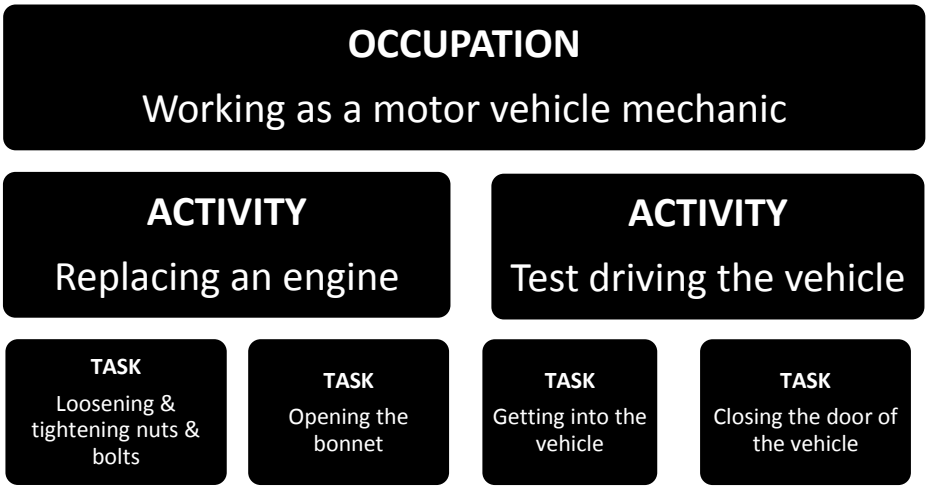


Figure 0.1 - Occupation, activity and task

Occupational therapist

A practitioner of OT, as described below. In South Africa, occupational therapists are required to register with the Health Professions Council of South Africa (HPCSA) as the regulating body.

Occupational therapy (OT)

OT is a health-care profession, with the main aim of enabling individuals or communities to engage in their chosen occupations as independently as possible, in order to allow for optimal quality of life to be experienced. Engagement in activity and occupation are used as main modalities of intervention (Hussey, Sabonis-Chafee, O'Brien2007:289).

Using the terms of the Kawa model, the purpose of occupational therapy is 'to help the subject enhance and balance this (life) flow' (Iwama 2006:162).

Patient versus client

For the purposes of this document, including the appendixes; the term 'patient' would be preferred to 'client'; since the persons involved are admitted to hospital as in-patients during participation in the study and/or group program.

Socio-cultural context

For the purposes of this study, the following definition will be used: cultural context refers to a patient's ethnicity, life roles and tasks, attitudes, customs, habits, beliefs and values. Hussey *et al.*(2007:124), supports this basic definition but add "expectations accepted by the society of which the individual is a member".

The Clinic

The original setting for this study. The facility is a private, sub-acute mental health care facility in the Free State.

The Second Clinic

Following problems in arranging the focus group at The Clinic, The Second Clinic was involved in this study. The Second Clinic is also a private mental health care facility in the Free State.

The Clinics

Refers to both The Clinic and The Second Clinic.

Summary

The aim of this study was to explore the occupations and socio-cultural context of the Sesotho speaking adult with mental health problems, attending either of the group therapy programs at The Clinic or The Second Clinic (both psychiatric hospitals in the Free State, South Africa). This exploration was undertaken due to a lack of literature and formal guidance on providing culturally relevant and meaningful therapy to the Sesotho speaking adult with mental health problems. Most sources of literature on occupational therapy in the field of mental health, originates in Western societies, specifically the United States of America and the United Kingdom; and are therefore not directly applicable to practice settings in South Africa.

Since the researcher wanted to 'understand' more about the daily experiences of the Sesotho speaking adult with mental health problems, a qualitative study of interpretive nature was conducted, with a collective case study as the strategy of inquiry. The first set of data was captured by conducting individual interviews with volunteering Sesotho adults as the sample. These interviews were based on the Kawa Model, a conceptual model of occupational therapy which uses the metaphor of 'life as river'.

The sample of patients that participated in the individual interviews, consisted of Sesotho speaking adults with mental health problems, admitted to The Clinic by psychiatrists. All participants were permanently employed, in jobs ranging from teaching and policing, to traffic officers and performance managers.

Data collected during the interviews based on the Kawa Model, needed to be supplemented specifically regarded the socio-cultural context of the Sesotho-speaking patient at The Clinic. A focus group interview was then conducted at The Second Clinic, to further explore the themes identified in the interviews. The sample of patients for

the focus group at The Second Clinic, was included according to the same selection criteria than with the individual interviews, and the sample was very similar to that of the individual interviews at The Clinic.

Data was analyzed by the researcher and two co-coders. The interpretive thematic analysis approach was used to first analyze the transcriptions of individual interviews, and thereafter the focus group interview.

Findings elaborated on the occupations and socio-cultural context of participants, as per the aim of the study. Participants were found to experience much stress at work, relating to strained interpersonal relationships. At the same time, their personal finances, family responsibilities and lack of sleep were found to be stressors. Participation in leisure, as well as experiencing work and family as sources of support (in spite of also regarding those as stressors), were regarded as positives in their daily occupational participation. Values that may influence occupational participation, were described as involvement in community and family; having a positive mindset and an active spiritual life. The participants' socio-cultural context was described as a context containing habits and 'ways of doing' with a strong influence on their occupations and relationships.

In conclusion, recommendations towards culturally relevant therapy, were made. These recommendations included suggestions for the content of an occupational therapy program, as well as suggestions for presenting such a program appropriately for the Sesotho speaking person with mental health problems. The limitations of the study were acknowledged and discussed, and recommendations for future research were set out.

Opsomming

Die doel van hierdie studie was om die aktiwiteitsverrigting en sosio-kulturele konteks van die Sesothosprekende volwassene met geestegesondheidsprobleme, te ondersoek. Die ondersoek is gedoen tydens persone se opname tot Die Kliniek of Die Tweede Kliniek (beide is psigiatriese hospitale in die Vrystaat, Suid-Afrika). Hierdie ondersoek is onderneem as gevolg van die beperkte literatuur en formele leiding relevant tot sinvolle terapie vir die Sesothosprekende persoon met geestesgesondheidsprobleme. Die meerderheid van bronne vir arbeidsterapie in geestesgesondheid, kom vanuit die Weste, spesifiek die Verenigde State van Amerika en die Verenigde Koninkryk, en is daarom nie direk van toepassing op praktyke in Suid-Afrika nie.

Met die doel om meer van die daaglikse ervarings van die Sesotho sprekende persoon met geestegesondheidsprobleme te verstaan, is ‘n kwalitatiewe studie vanuit ‘n interpreterende benadering uitgevoer. Die kollektiewe gevallestudie is as navorsingstrategie gebruik. Die eerste stel data is d.m.v. individuele onderhoude met vrywillige Sesotho persone as die steekproef, ingesamel. Hierdie onderhoude is op die Kawa Model, ‘n konseptuele model van arbeidsterapie, gebaseer. Die Kawa Model maak gebruik van die metafoor van ‘my lewe as ‘n rivier’.

Die steekproef van pasiënte wat aan die individuele onderhoude deelgeneem het, het bestaan uit Sesotho sprekende volwassenes wat by Die Kliniek opgeneem is met geestegesondheidsprobleme, deur psigiaters. Al die deelnemers was permanent werksaam in ‘n verskeidenheid van poste wat wissel van onderwys en die polisie, tot verkeerspolisie en prestasie beamptes. Data ingesamel tydens die onderhoude geskoei op die Kawa Model, het aanvulling nodig gehad om spesifiek die sosio-kulturele konteks van die Sesotho sprekende persoon te kon beskryf. ‘n Fokusgroep is aangebied

by Die Tweede Kliniek, om die tema's wat tydens die onderhoude geïdentifiseer is, verder te ondersoek. Die steekproef van pasiënte wat hieraan deelgeneem het, is geneem uit Die Tweede Kliniek, volgens dieselfde kriteria as met die individuele onderhoude. Die steekproef was soortgelyk aan die van die individuele onderhoude by Die Kliniek.

Data is deur die navorser en twee ko-kodeerders geanaliseer. Die benadering van interpreterende tematiese analise is gevolg om eers die transkripsies van die individuele onderhoude, en daarna die fokus groep onderhoud, te analiseer.

Bevindings het die aktiwiteitsverrigting en sosio-kulturele konteks van deelnemers beskryf, soos deur die doelwit van die studie gerig. Dit is bevind dat deelnemers hoë vlakke van werkstres ervaar, wat verband hou met problematiese interpersoonlike verhoudings. Terselfdertyd is bevind dat persoonlike finansies, verantwoordelikhede rondom familie en 'n gebrek aan slaap, ook stres veroorsaak. Vryetydsbesteding, asook die ondersteuning verkry vanuit verhoudings met familie en vriende, is aangedui as positiewes in daaglikse aktiwiteitsverrigting; hoewel verhoudings met familie en vriende ook aangedui is as bronne van stres. Waardes wat aktiwiteitsverrigting beïnvloed, is beskryf as betrokkenheid in die gemeenskap en by familie; die behoud van 'n positiewe ingesteldheid asook spirituele belewenis. Die deelnemers se sosio-kulturele konteks is hierna beskryf as 'n konteks vol gewoontes en 'maniere van doen' – wat deelnemers se aktiwiteitsverrigting en verhoudings daadwerklik beïnvloed.

Ter opsomming, is aanbevelings t.o.v. kultureel relevante terapie gemaak. Hierdie aanbevelings sluit in voorstelle vir die inhoud van 'n arbeidsterapie program vir Sesotho persone met geestegesondheidsprobleme, asook voorstelle vir die toepaslike aanbieding van so 'n program vir die populasie. Ter afsluiting is die beperkings van die studie bespreek, en daarna is voorstelle vir toekomstige navorsing uiteengesit.

Preface

The purpose of this preface is to provide the reader with contextual background, explaining my personal and professional background related to the study, as well as my intention with the study. Specific assumptions, fundamental to the study, are also mentioned.

My experience of culture: as a person

I was born in South Africa during the apartheid era, into a white, Afrikaans speaking family. I grew up in rural North-West Province, in a community consisting of white Afrikaans speaking farming families. My contact with the local black Setswana speaking people, was limited to positive and friendly encounters, such as my friendship with the children of the Tswana woman who worked in our household. I attended Louwna Primary School, a small Afrikaans school with only 27 learners in my last year of attending. Thereafter I attended Vryburg High School, a school internationally infamous for racial tension during the years 1995 – 1999. These five years happened to be the five years I attended there, and I was witness to many unsettling events – between 'black and white' (Tswana and Afrikaans) – both on the playground and in classrooms. These experiences lead me to the belief that culture is so much more than race – it seemed to be a 'way of doing things'. I also experienced firsthand that when culture is misunderstood it could lead to much hurt and anger.

My experience of culture: as an occupational therapist

Studying on the campus at the University of the Free State, I once again walked into an institution where people from different races experienced difficulty working and living

together. During my occupational therapy studies and clinical placements, as well as during my Community Service year at Pelonomi Regional Hospital in Mangaung, I had contact with many black, Sesotho speaking people. Providing a service to people from a background so different to mine, I soon realized I would have to learn ways of engaging with them, in order to be able to render therapy which is both meaningful and effective. These ways of engaging entailed much, much more than Sesotho greetings such as a simple 'Dumela mme' (translating to *good day madam*). Instead, I soon learned that family was very important to most Sesotho speaking people and that it was therefore absolutely necessary to involve the family in treatment. Also, I learned about independence not necessarily being the ultimate goal for all patients – especially when the patient was a Sesotho 'elder' and his/her family was available and willing to take care of him/her. Also, I learned that Christianity for many Sesotho speaking persons, included 'traditional' religion (i.e. praying to their forefathers). All of these lessons I learned with at least a bit of surprise, myself coming from a 'culture' where I was taught to have boundaries, even in families. A culture which allowed families to have their 'elders' admitted to a care facility instead of personally taking care of them. A culture abiding to Christianity without any consideration of forefathers. A culture in such great contrast with what I perceived to be the culture of the Sesotho speaking person.

Travelling to the United Kingdom (UK) to work as an occupational therapist, I did not expect to be confronted with the issue of different cultures as much as in South Africa. And yet, there I was being told off by elderly British patients when I, by way of expressing respect, addressed them as Mister, Sir or Missus. Without exception, they explained that they would rather be addressed by first name. (In South Africa, Afrikaans people fifty years my senior would mostly appreciate being addressed in a respectful way as 'oom' or 'tannie'; meaning 'uncle' or 'aunty'.) This, to me, was another encounter with 'cultural differences' – this time with people who, if culture was equal

to race, shared my culture. Also, whilst working as occupational therapist in a care facility, my nursing colleagues complained about their 'difficult patient'. This man, 'the Nigerian', spoke some native language, which provided the nurses with ample communication and caring challenges. After some investigation, I discovered that 'the Nigerian' was a Nigerian born British Citizen; a professional engineer who has worked in the UK for several years prior to suffering a massive stroke and ending up in this care facility. I could thus assume that he was proficient in English, and only reverted to his native tongue (possibly Yoruba) during this phase of poor health. This discovery was a relief, since I could only speak English and definitely not Yoruba! I engaged 'the Nigerian' in therapy by speaking English simply and slowly, and was pleasantly surprised by his level of understanding and participation, and his attempts to communicate with me in English! By not allowing my own and other persons' presumptions about this person's 'culture' to stand in the way, we could engage him in meaningful therapy in a dignified and purposeful manner.

Returning to South Africa, I was afforded the opportunity to present occupational therapy groups at a mental health clinic in the Free State. The people attending the groups were mostly, if not all, black Sesotho or isiXhosa speaking adults. However, my fellow presenters of the group therapy program (which was presented in English) and I, were all Afrikaans or English speaking white females.

Observation during the facilitation of group therapy sessions, conversations with colleagues, and feedback from patients, led me to question whether I knew enough about the occupational participation and socio-cultural context of the patient population. Very often, I would be surprised when a patient explained a certain problematic social situation, starting by saying 'In my culture….' Also, patients would describe activities such as house-cleaning as leisure, where I would rather classify it as 'personal care' or even 'productivity'. Once, during a group session on effective

communication, the conversation steered towards communication in marriage. After a patient described certain marital problems she was struggling with, I suggested it might be beneficial to see a marriage counselor or psychologist together. However, the patient and other group members described that 'in their culture', it would be more appropriate to get the parents of both husband and wife together, who would then be expected to offer advice to the couple.

The paragraphs above sketch only some of the most significant encounters I had with 'culture' in my life so far. All of them had an influence on my thoughts about meaningful therapy for clients with a seemingly different culture than mine. You might wonder why I even need to know anything about my client's culture in order to plan appropriate intervention. My answer would be based on two reasons. Firstly, referring to therapeutic use of self: I believe that a therapist intuitively builds her 'therapeutic use of self' on her own culture. This may be evident in her communication style, sense of humor, as well as attitudes and prejudices. I should therefore strive to a better awareness of my patient's cultural context, in order to adapt my 'therapeutic self' in order to benefit my patient, instead of expecting the patient to benefit from my therapeutic self – even when it could possibly cause him offense. Secondly, when choosing intervention goals with my patient, I may prioritize goals according to my own culture, albeit subconsciously (especially goals based on independence and autonomy); whilst my patient might prefer goals that are totally different – but more coherent with his culture.

From the descriptions above, I have inferred certain personal assumptions, which played an important role in the birth of the research question for this study. I would like the reader to consider these assumptions carefully, since they provide a backdrop to the whole of the study and this dissertation.

Assumptions

- Culture is not limited to race and ethnicity.
- Culture may refer to any or all of the following: ethnicity, race, language, life roles and tasks, attitudes, customs, habits, beliefs and values.
- Culture can only be depended by association, i.e. I may, or may not, choose to associate with the Afrikaner culture.
- Sub-cultures exist within culture; i.e. Afrikaners from different towns may have differing habits and customs.
- A person's cultural context ('being') guides his/her behaviour and choices relating to occupations ('doing').
- It is my duty as occupational therapist, to consider my client's culture (as described by himself), during all the stages of the intervention process.
- In relation to the previous assumption, I should add that at no time should a person's culture be allowed to become 'the problem' in the therapy process.
- This study does not intend to provide a 'one size fits all' occupational therapy strategy for all Sesotho speaking adults with mental health problems. It is rather a humble attempt to understand more about the socio-cultural context within which the Sesotho speaking adult with mental health problems engage in his occupations. This knowledge may enable me as occupational therapist to provide therapy that is more relevant to my Sesotho patient's background.

Chapter 1

Introduction and Orientation

1.1 INTRODUCTION

The question that summarizes the inspiration behind this study, is:

> *Can we truly help another human being without knowing what he or she experiences..? (Yerxa 2009:492)*

The researcher, an occupational therapist, has been working at two private psychiatric hospitals in Bloemfontein, where occupational therapy groups are presented as part of the psychosocial group therapy program.

The typical patient attending the English group therapy program at both The Clinic and The Second Clinic, is Sesotho speaking, male or female, living in the Mangaung Municipal Area and employed in the public sector. Diagnoses mostly include mood and anxiety disorders. Patients with psychotic features, or cognitive impairment, are not included in the group therapy program and are treated individually. Decisions with regards to inclusion in the group therapy program are made by the attending psychiatrists and the group therapy coordinator; in liaison with the occupational therapists.

The group therapy programs at both Clinics are presented in English, by occupational therapists and psychologists, most of whom are Afrikaans speaking, white females. Topics in the current occupational therapy sections of the programs include stress and time management, communication skills, novel recreation activities, problem solving skills and value clarification. These topics are indicated by literature to be appropriate

and essential occupational therapy goals for a population with mood and anxiety disorders (Cara 2005:176; Hawkes, Johnstone & Yarwood 2008:403). However, these sources by Cara (2005:176) and Hawkes *et al*. (2008:403) have respectively been published in the United States of America (USA) and the UK, and have made no mention of the appropriateness of these topics for people in other countries. The South African literature available for occupational therapy (OT) practice in mental health settings, also propose similar programs for people suffering with mood and anxiety disorders (cf. Chapter 2), however without specific guidelines to enhance cultural appropriateness (Crouch & Alers 2010; Duncan 2005:442; Van Greunen 2005:272-283). Again, Yerxa's (2009:492) question in the opening paragraph is relevant, as well as the following astute comment by Iwama (2005a:214):

> *No longer can we proceed into cultures …different from our own…and merely tell or instruct the other how to comprehend and apply **our** truths into **their** realities. (Emphasis own).*

The socio-cultural context of our patients might play a much more important role than reflected in South African literature on occupational therapy. Even though the occupational therapists and patients at The Clinics share many similarities, different socio-cultural contexts seem to be sticking out as the main difference and possibly the main stumbling block towards best practice. Improved cultural competence - broadly defined as the sensitivity towards, respect for and awareness and knowledge of other cultures (Creek & Lougher 2008:580) - is required here! However, the involved therapists and researcher already regard themselves as partially culturally competent; being sensitive towards and having much respect for the meaning and role of culture in therapy. It seemed that a lack of knowledge about the occupations, and socio-cultural

context in which these occupations of daily life are chosen and performed, could be the problem.

Acquiring knowledge about the occupations and socio-cultural contexts of patients could certainly be an attainable goal, but occupational therapists Fitzgerald, Williamson and Mullavey-O'byrne (1999:41) warn against the use of culture as a "ready, but not necessarily accurate, explanation for many problems in health care settings". Iwama (2005b:243), an occupational therapist known for his urgent calls on occupational therapists to take into account the cultural context of a patient, supports this statement. This author (Iwama 2005b:243) explains how focusing on and even blaming the "culture" of a patient, may prevent a therapist from actually looking at the "broader social context that might better explain the subject's particular conduct and behaviour". Nelson (2007:242) uses the terms "the other" and "othering", warning about the pitfalls of cross-cultural research, where research focuses on "other" people.

Adams (2009:8) acknowledges that culture can guide behaviour and occupational choices, but states that it is "up to individuals within a culture to interpret beliefs, traditions and customs for themselves". This can lead to a "variation in expression and behaviour". Iwama (2005b:243) expands on this statement, by warning that culture should not be treated as "synonymously with race and ethnicity", a viewpoint very strongly supported by the researcher. He (Iwama 2005b:251) seems to ask the occupational therapist to consider two viewpoints on the culture of her clients: will I expect my patients to think about occupation the way I do - even though I regard myself as sensitive towards cultural needs and differences? Or will I consider moulding OT and my view of occupation to suit my patient's reality and view on occupation?

This touches on a very important discourse currently ongoing in OT: do occupation have the same meaning to people from different cultural contexts? Can occupation be seen as a cross-culturally applicable construct (Iwama 2005b:243)? If I reflect on Wilcock's article (1999:1) about "doing, being and becoming", do I pay enough attention to my patient's "being" (the essence and socio-cultural context of a person) before zooming in on his "doing" or occupations (Watson 2006:151)?

The questions described in the previous two paragraphs have been summarized by the researcher in a typography below (Figure 1.1), inspired by the chapter "Occupation as a cross-cultural construct" by Iwama (2005b:242-253).

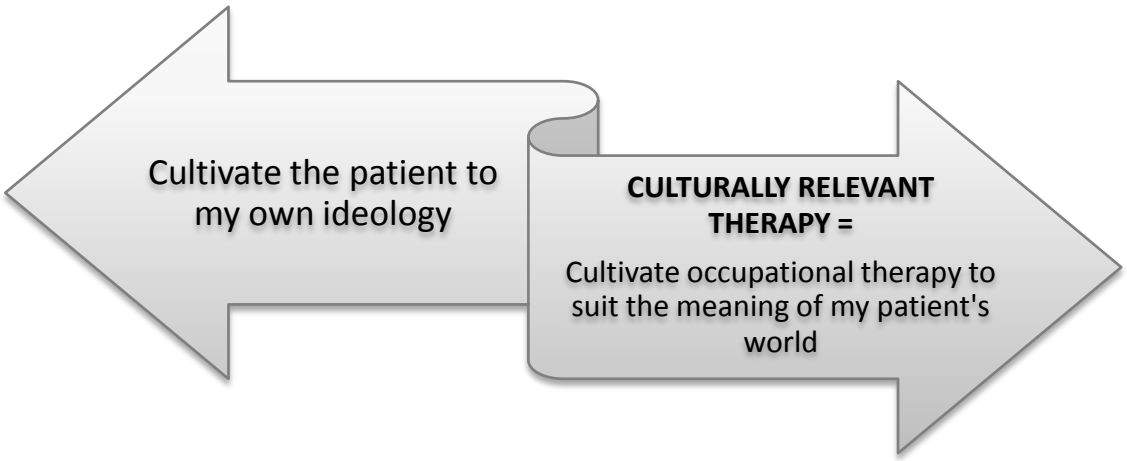


Figure 1.1 - Towards culturally relevant therapy (by M.E. Vermaak)

With occupational therapists not necessarily being an authority on culture, anthropological sources were consulted. Ms. Shirley du Plooy from Dept. Anthropology, UFS (2009), conceded that 'culture' was very difficult to define and determine. This was also confirmed by anthropological writers Borofsky, Barth, Shweder, Rodseth and Stolzenberg (2001:434).

The following comment by an anthropologist (Borofsky *et al.* 2001:434) – steered the study back to the familiarity of the OT profession:

> *If one focuses on culture – without first taking into account an action-oriented approach to knowledge and human experience – important dynamics tend to get shunted to the side.*

It seems that Borofsky *et al.*(2001:434) is urging the researcher to look beyond culture at the human experience, namely the 'doing'. In OT, the human experience could be considered – by enquiring about the socio-cultural context within which patients perform their daily occupations, thus acknowledging the person's 'being' and 'doing'. Occupation; and its' contextual influences are concepts reconcilable with the overall aim of this study: to explore the occupations and socio-cultural context of Sesotho speaking adults admitted to The Clinics with mental health problems.

1.2 PROBLEM STATEMENT

The population of patients at both Clinics mainly consists of Sesotho adults, male and female, working in the private or public sector; all suffering with mental health problems. They attend the psychosocial group therapy programs, where the

occupational therapists, who are Afrikaans speaking females, present group therapy on a daily basis.

Minimal literature and guidelines are available with regard to culturally relevant OT practice for this population, and more information is needed on the occupations and socio-cultural context of the patients attending the group therapy program. Guidelines that are available for OT in mental health, are based on traditional conceptualizations of occupations, from the West (i.e. USA and UK), and is possibly not relevant to the Sesotho speaking population in South Africa.

Five components of such culturally responsive caring have been identified by Muñoz (2007:265), including: 'generating cultural knowledge, building cultural awareness, exploring multiculturalism, applying culturally skills and engaging culturally diverse others'. An exploration of the occupations of the Sesotho speaking person with mental health problems, in consideration with his socio-cultural context, would hopefully generate *cultural knowledge***,** allowing culturally relevant practice to the patients attending the group therapy programs at both Clinics.

1.3 RESEARCH QUESTION

What are the occupations and socio-cultural context of the Sesotho speaking adult at both The Clinic and The Second Clinic?

1.4 AIM OF THE STUDY

To explore the occupations and socio-cultural context of Sesotho speaking adults admitted to The Clinics with mental health problems.

1.5 METHODOLOGY

To fulfill the aim of the study, an exploration of the daily lives of participants was needed, including the socio-cultural factors impacting on their choice and performance of occupation. Secondly, the study prompted for an 'insider's perspective' (the perspectives of participants) as part of the data used to answer the research question, and thirdly – was open to get emerging findings. These three comments are in line with qualitative research as described by Whiteford (2005:41).

A qualitative study of interpretive nature was therefore conducted (Henning, Van Rensburg & Smit 2004:17; Snape & Spencer 2003:16). The first set of data was captured and analyzed from a collective case study, by conducting individual interviews with volunteering Sesotho adults as the sample (Bowling 1997:360; Fouchè 2005a:272; Henning et al. 2004:32; Lewis 2003:76). The interviews were based on the Kawa Model, a conceptual model of occupational therapy which uses the metaphor of 'life as river' (Iwama 2005a:213-227). Data was analyzed according to the interpretive thematic analysis approach (Carpenter & Suto 2008:48), by the researcher and two co-coders.

Data collected during the interviews based on the Kawa Model did not generate sufficient data to allow a detailed description of the socio-cultural context of the Sesotho-speaking patient at The Clinic. The researcher, co-coders and study leaders decided that a focus group interview would be ideal to further explore the themes identified in the interviews. A focus group session was conducted at The Second Clinic to gain more information on the socio-cultural context of the population, all the while also considering occupational participation. The focus group was facilitated by the researcher, with group members from the same patient population than the

interviews. The reasoning behind data collection at two separate Clinics, is explained in Chapter 3 (cf. 3.4.1).

Data was analyzed by making use of the same approach that was used in the analysis of individual interview data (interpretive thematic analysis), by the researcher and the same co-coders. The study design and methodology is described in detail in Chapter 3.

1.6 SIGNIFICANCE OF THE STUDY

Currently, occupational therapists working with Sesotho speakers in mental health settings, are doing so without any guidelines from South African literature on culturally relevant practice (available literature on culturally relevant practice is mostly from the UK or USA). The findings of this study would hopefully expand the knowledge available on the occupations and socio-cultural context of the patient population presented at both Clinics. The findings could be used to make recommendations with regards to the content and presentation of the OT group programs at Both Clinics, with the aim to offer the best possible service to the approximately 30 patients admitted fortnightly. Recommendations would allow therapy to consider the socio-cultural context of the patients, and their understanding and view of occupations.

Even though generalizations cannot necessarily be made from the findings of the study, other practitioners from other clinics elsewhere, may choose to transfer and apply some of the findings to their own practices. With the aim of making findings available to the OT practices at both Clinics, and to other practitioners in South Africa; publishing in accredited journals or otherwise, as well as presentations at conferences, will be considered. This expansion of knowledge about the topic would hopefully be one of the

first steps towards culturally relevant practice with similar populations in mental health settings.

1.7 ETHICAL CONSIDERATIONS

Guidelines for ethical and responsible conduct were followed during the planning and execution of the study (Carpenter & Suto 2008:50; Lewis 2003:66; Strydom 2005a: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 summary, the following ethical considerations were taken into account: informed consent; no harm to participants; privacy and confidentiality of participants and no deception of participants by the researcher. Informed consent was obtained from all participants; as well as formal consent from the management of The Clinics and the private occupational therapy practices involved in the study. Information was treated confidentially by the researcher and all other parties involved in the study. The study was designed in such a way that no harm was implied to any participant. Also, the drive behind the study was to provide a more relevant service to the population involved in the study, which links to social responsivity. Findings will be made available to the Management of both Clinics, also to the Occupational Therapy practices involved in presenting the group therapy program.

The final research proposal was approved by the Ethics Committee of the Faculty of Health Sciences, University of the Free State (ETOVS 150/2010) in October 2010.

1.8 OUTLINE OF CHAPTERS

Chapter 1, the Introduction and Orientation, provides an overview of the study. Following the introduction, the problem statement and the aim of the study is discussed in short. A summary of methodology is included, as well as the significance of the study. Ethical considerations have been summarized, and the outline of chapters in this dissertation has been done.

Chapter 2, A Review of Literature, has been written to provide the reader with essential information pertaining to some key concepts in this study. The link between occupation and health is described, whereafter occupational therapy is plotted in the practice of mental health interventions. Culture is acknowledged as a significant factor in the choice and performance of occupations, and is therefore discussed within the practice of occupational therapy. The reader is then introduced to the Kawa Model as the conceptual model for this study, and in closure, the Sesotho speaking adult is described.

In **Chapter 3**, the Research Methodology is described in detail. This study followed a qualitative approach, from an interpretive research paradigm. A collective case study was used as design, with Sesotho speaking adults at The Clinics as the sample. Individual interviews, according to the Kawa Model; and a focus group, have been conducted by the researcher in order to collect data on the occupations and socio-cultural context of the sample. Interpretive thematic analysis of data has been done by the researcher and two co-coders. Strict guidelines with regards to ethical conduct have been followed.

Chapter 4 contains the Presentation and Interpretation of Findings. The participants to the interviews (individual and the focus group), are introduced to the reader by way of essential biographical data[1]. Following this introduction, findings are discussed according to the main themes and categories emerging from data. Theoretic triangulation, a strategy employed in ensuring trustworthiness, allowed the researcher to incorporate several new sources of literature to add to the discussion of findings. The chapter concludes with a final interpretation of findings according to the Kawa Model, in which the researcher could draw conclusions about the links between the relevant themes.

Chapter 5 offers the conclusions and recommendations, regarding occupational therapy for the Sesotho speaking adult with mental health problems. The limitations of the study are also discussed, leading to recommendations for further study.

1.9 CONCLUSION

In this chapter, the background and framework to this dissertation has been sketched. In the next chapter, a review of literature will highlight the importance of this study, and provide the reader with information for contextual reading of the dissertation.

[1] Biographic data provides details about a person's life; whereas demographic data describes a population in terms of statistics (i.e. density and distribution). Biographic data was therefore deemed as a more appropriate term in this qualitative study with a relatively small sample.

Chapter 2

A Review of Literature

Chapter 1 provided an overview of the study, and announced the aim of this study as a description of the occupations and socio-cultural context of Sesotho speaking adults with mental health problems.

In this chapter, the primary review of literature relevant to the background of this study is presented. With the study taking on a qualitative nature, theory triangulation is used to verify data (Creswell 2009:191; Flick 2002:226; Lewis & Ritchie 2003:276), and a secondary study of literature (or literature control) would therefore take place in Chapter 4 when findings are discussed.

The purpose of this literature review is to provide a solid theoretical context for the study (Bailey 1997:13); as well as to present the knowledge available on the topic in question: the occupations and socio-cultural context of the Sesotho speaking adult (Henning *et al.* 2004:27; Polgar & Thomas 2008:274).

Sources that have been reviewed for relevant literature, include books on 'Occupational therapy and mental health' from the UK (Creek & Lougher 2008), and South Africa (Crouch & Alers 2005 & 2010). The researcher conducted electronic

searches on Ebscohost, and further searches for journal articles have been done with the help of staff at the Frik Scott Library (University of the Free State). Appendix A contains a table containing the details and results of these electronic searches.

The themes presented in this literature review, cover all the keywords of the topic: occupations, socio-cultural context, Sesotho speaking adults. Two other aspects, directly related to the study, were included: occupational therapy in mental health settings, as well as the Kawa model – the conceptual model used in planning, executing and interpreting the study.

2.1 OCCUPATION AND OCCUPATIONAL THERAPY

Occupation as layman's term, may refer to an area of employment - a job, profession, craft or vocation (Webster 2005:321). However, occupation defined by occupational therapists and occupational scientists alike, refers to purposeful and meaningful participation in activities ranging from self-care, productivity and leisure (Wicks & Whiteford 2008:199).

Occupations are conceptualized in several different ways, dividing occupations in separate domains. The Canadian Model of Occupational Performance (CMOP) divides occupations into self-care, productivity and leisure. Kielhofner's Model of Human Occupation (MOHO) does not provide specific domains for occupations, but divide the 'human system' into three categories: human system is divided into three subsystems: volition (including values, interests and personal causation); habituation (referring to habits of occupational behavior); and mind–brain–body (the person's capacity to perform occupations).

Brooke, Desmarais and Forwell (2007), in a post-hoc analysis of a study of the occupations of people with multiple sclerosis, came to the conclusions that 'that category systems should be used cautiously' (2007:281) They warn therapists to' be careful not to compromise the therapeutic process by imposing frameworks embedded in the practice culture that may not reflect the unique worldview of the client' (2007:293). In the present study, it is possible and even expected that the chosen conceptualization of occupational domains (sleep, work, leisure and social participation), is not appropriate for the population. However, this assumption will not be made prior to conduction of the study, and data would hopefully highlight the need for a different conceptualization of occupations – if needed and appropriate.

Occupational therapists view the human being as an occupational being - with participation in occupation as the essence of human life (Blair, Hume & Creek 2005:26; Molineux 2004:2). Similarly, occupational therapists expect dysfunction when occupational participation is restricted, due to internal or external factors, often out of the control of the person (Molineux 2004:3). In promoting a person's health and wellbeing (Kramer-Roy 2005:328), occupation is regarded as the occupational therapist's 'tool', his therapeutic modality of choice (Molineux 2004:4). Scientific knowledge of occupation is therefore at the roots of the profession of occupational therapy (Hussey*et al.* 2007:52) and is essential for informed practice (Zemke & Clark 1996:vii-xvi).

'Occupation-based practice' is quite the focus in occupational therapy at the moment, as opposed to the more traditional way of focusing more on specific, singular skills (Creek 2008:77; Hussey *et al.* 2007:52). Molineux (2004:3) describes this kind of

practice simply as helping the individual to solve everyday problems – problems that arise from problematic occupational performance.

In the attempt to provide meaningful, occupation-based practice, the therapist has to consider the person's identity and personal factors (e.g. abilities, strengths and needs); as well as environmental factors - including physical and social contexts (Creek 2008:77; Whiteford, Klomp & Wright-St.Clair 2005:10). All these factors may impact on the level and quality of participation in occupation (Henderson 1996:420; Hussey *et al.* 2007:289; Kramer-Roy 2005:328; Townsend & Egan 2005:197; Whiteford *et al.* 2005:10). Chapparo and Ranka (2005:62) acknowledge the importance of context, but go further to stress the impact of life-roles, contending that people "*carry out their daily lives in concert with life-roles*". Occupation, situated in the centre of the human experience, is therefore dependent on many contexts (Whiteford *et al*. 2005:10):

> *All occupation takes place in a context. No action is independent of the social, cultural, historic, political and economic context in which it occurs. These contextual forces… shape the... performance of the occupation as well as the meaning ascribed to it by and individual or group.*

Not only are many contexts hence relevant in the occupational experience of human existence but also the very complex interplay and dynamics between them. The present study will focus specifically on the influence of the socio-cultural context of the Sesotho speaker on his occupations, which are explored in 2.4.

With occupation situated in the centre of the human experience, it is also expected to have an influence on a person's health, an idea discussed in the following section (2.2).

2.2 OCCUPATION AND HEALTH

It is a well-known assumption in occupational therapy practice that balanced participation in occupations, is required for overall well-being, including mental health (Blair *et al.* 2008:26; Chapparo & Ranka 2005:57; Creek 2008:76; Molineux 2004:2). A study conducted in South Africa by Van Niekerk (2005:65), confirmed that this assumption is shared by mental health care users, as shown in the following statement:

> *The need to balance occupational expectations and their own ability to tolerate the stress that resulted from such participation, emerged as a strong concern. For many participants, finding such a balance was motivated by a need to prevent the horror of having to live through another relapse (Van Niekerk 2005:65).*

A person's balanced participation in occupations, is hindered by occupational risk factors. These factors, which may impact negatively on occupational balance and participation, are terms now often used in occupational science, and include occupational deprivation, imbalance and alienation (Blair *et al.* 2008:27; Van Niekerk 2005:69). All of these refer to the possible negative impact of contextual factors (often beyond a person's control) on occupational opportunities and participation, and once again affirms the imperative link between occupation and health (Blair *et al.* 2008:21-23).

Chapparo and Ranka (2005:67) identify three theoretical opinions in occupational therapy about health and ability. The first relates to the traditional bio-medical model,

and regards health as “the absence of disease and impairment”. However, this is in stark contrast with the definition of health as proposed by the World Health Organization (WHO): “A state of complete physical, mental and social well-being, *and not merely the absence of disease”* (WHO 2011: online). The former theoretical opinion of health, above; is thus rejected for the purposes of the current study.

The second opinion, in the paragraph above, regards health as “personal ability and adaptation” (Chapparo & Ranka 2005:58) and links well to the current programs at The Clinic and The Second Clinic; which are rehabilitative, and directed at assisting patients to master life skills to enable them to cope with the demands of daily living as well as the impact of mental health problems.

The third opinion sees health as “social equity and opportunity”, an opinion which resonates with ‘occupational justice’ – a term used by prominent scholars in occupational science (Wilcock & Hocking 2004:220). If occupational justice is pursued, it allows the incorporation of the different occupational needs of its individuals and/or communities.

The opinion of health as “personal ability and adaptation” is highly relevant to the types of programs at both Clinics; but the questions on which the aim of the current study is based, arise from this opinion of health as “social equity and opportunity”. At the same time, the study will be conducted from the viewpoint of health as “personal ability and adaptation”.

The World Health Organization (WHO) regards health as a combination of physical, social and mental health (WHO 2011:online). Mental health, from the viewpoint of

occupational therapy and in the context of the current study, is considered in the following section.

2.3 OCCUPATIONAL THERAPY AND MENTAL HEALTH

"There is not health without mental health": an astute statement made by Van Bruggen (2008:xi). Mental health is described by Blair *et al.* (2008:17) as the ability to cope with life, including its changes and adaptations. It is also the ability to experience life as satisfying, while setting personal aims and reaching it.

The population admitted to The Clinic suffer with psychiatric diagnoses including mood disorders (i.e. major depressive disorder; bipolar mood disorder and post-partum depression), and anxiety disorders, amongst others. These diagnoses are characterized by symptoms such as anxiety, poor self-esteem and disturbed thought processes, which leave the person with disturbances in occupational functioning (Hawkes *et al.* 2008:393). Comparing these symptoms to Blair *et al.'s* (2008:17) description of mental health above, it is obvious that a person's "ability to cope…adapt…and achieve life satisfaction" would be affected.

It is argued by scholars that a main outcome for all clients of occupational therapy, is to enable optimally independent, and balanced participation in occupations (Duncan 2008:516; Paterson 2008:14). The World Federation of Occupational Therapists (WFOT) provides this definition of occupational therapy, in Kramer-Roy (2005:328):

> *(Occupational therapy is) a healthcare profession based on the knowledge that purposeful activity can promote health and wellbeing in all aspects of daily life. The aims are to promote,*

> *develop, restore and maintain abilities needed to cope with daily activities to prevent dysfunction and …. to facilitate maximum use of function to meet demands of the … environment.*

Peloquin (2005:106) quotes the wellknown definition of occupational therapy provided by the American Occupational Therapy Association (AOTA) in 1972: "the art and science of directing man's participation in selected tasks…". In a powerful chapter on the art of occupational therapy, she refers to an important dimension of therapy as initially proposed by Mosey: the way the profession can lead people to awareness of their own potential, and equip them to reach and use it (Peloquin 2005:106).

Both these definitions of occupational therapy (WFOT and AOTO), as well as Mosey's idea of occupational therapy (sensitizing people for their own potential and allowing them to reach it), links well with the theory that health is 'personal ability and adaptation' (Chapparo & Ranka 2005:58).

This view of therapy possibly summarizes the current vision of the OT group therapy programs at both Clinics: to equip patients with life-skills, or 'tools', as the researcher and her patients often calls it. These life-skills may maximize the person's potential to cope with daily occupational demands, which in turn promotes the prognosis for well-being and mental health (Blair *et al.* 2008:17 & 25; Roberts 2008:364-368).

The OT programs at both Clinics are in line with Western literature, and the question arises: is the 'culture' of the patient considered? The following section explores the role, if any, of culture in occupational therapy.

2.4 CULTURE AND OCCUPATIONAL THERAPY

It seems that occupational therapy has been, and still is, going through an ongoing discourse on 'culture in occupational therapy', and this part of the literature review will aim to reflect this conversation to a certain extent.

The Occupational Therapy International Journal published a special edition on 'culture in occupational therapy', in 2007. In this edition, Iwama (2007:183) writes a scientific letter in which he reminds occupational therapists of the promise of occupational therapy – to empower people to engage in activities meaningful to *them* (Iwama 2005b:243; Iwama 2007:183; Iwama 2009). He then states that the value of occupational therapy is directly related to the relevance of therapy to the client's needs. Iwama's contention is also related to the researcher's question to herself: how does culture influence the client's needs, and ultimately the choices clients make to integrate the occupational therapy provided to them?

If culture would be reduced to so-called race and ethnicity, with specific characteristics to be simply taken into account, this study would serve no purpose (Lim 2008:252). On the contrary, Iwama's (2005b:245; 2007:184;) definition of culture should be considered: [culture is] "shared spheres of experience and the ascription of meaning to objects and phenomena in the world". This definition is supported by anthropologists Borofsky *et al*. (2001:434), who warn that the human experience as a whole should also be considered, rather than only focusing on the traditional definition of culture.

No matter what definition of culture is used, a therapist remains at risk of attributing a person's 'problems', even his seeming non-compliance to therapy for example, to his culture being different….being other than her own (Iwama 2005b:243)! Even whilst

regarding herself as culturally competent (Iwama 2005b:244), it is here that a therapist needs to consider the direction she is taking in therapy: will the client have to adapt to the therapist's idea of therapy, or will the therapist adapt therapy to be more meaningful to the client (cf. Figure 1.1)?

If a therapist earnestly wants to cultivate her therapy to be more meaningful to her clients' needs, the starting point would be to investigate the link between occupations and culture. Although many scholars concur on the importance of considering culture at any given point during the therapeutic process, it seems that much less is said about *how* to transcend cultural barriers in everyday practice.

Watson (2006:156) is of opinion that we might have to consider and know a person's 'being' before assuming we know anything about his 'doing'. In other words – we need to understand a person's socio-cultural context in order to understand his choice and performance of occupations (Wilcock 1999:4). Adams (2009:10), in concurrence with Wilcock (1999) and Watson (2006) and Watson and Swartz (2002), concludes that culture could impact the occupations of a person in his choosing and performance thereof.

Iwama (2005b:251) on the other hand, describes occupation from a Japanese background. It seems that the concept of 'doing, being and becoming' (Wilcock 1999), does not leave space for 'belonging' in a social context, which is so important for the Japanese person with a collectivist worldview. He urges occupational therapists to go beyond the discourse on 'cultural competence' (the awareness and knowledge of, and sensitivity towards, the culture of patients). This venture beyond cultural competence

would entail the study of the meaning of occupation in different social contexts (Iwama 2005b:251-252).

The researcher agrees with Iwama (2005b:251-252) on the importance of finding out more about the meaning of occupation in different social contexts, since trying to obtain cultural competence may include looking more at how 'different' people are, rather than how 'similar'. This way of looking at people has been coined 'otherism' by Abreu and Peloquin (2004:353-355). With the present study aiming to explore some characteristics of a specific population, it needs to be understood that 'othering' is not the aim and may perhaps even be suggestive of ethically questionably practice. Rather, the aim is to describe the specific population as occupational beings, whose choice and performance of occupations may be influenced by their specific socio-cultural context. The researcher is hence attempting to move away from universalist assumptions of the so-to-speak 'cultural nature' of occupation.

Going further than maintaining culture as race, ethnicity and a simple set of rules; and cultural competence – in which a therapist will know how to engage the 'other'; Muñoz (2007:265) conducted a study on culturally responsive caring in occupational therapy. Five components of such caring have been identified, including: 'generating cultural knowledge, building cultural awareness, exploring multiculturalism, applying culturally skills and engaging culturally diverse others'. With the present study focusing on the generation of cultural knowledge, it is important to reflect on Muñoz's opinion (2007:266) that this is a process of learning to understand the world-views of clients from a range of cultural backgrounds. In this context, culture would be acknowledged to be more than mere demographics such as race and ethnicity; and the existence of sub-cultures within any one 'culture' is also acknowledged. This statement is confirmed

by Muñoz (2007:268). This process of applying cultural skills, broadly refer to acknowledging that the client is from a specific culture, and applying this in every step of the therapy process. In lieu of formal cultural assessments, the occupational therapists in Muñoz's study, would include questions in their interviews with patients, about culture and the influence thereof on therapy. They defined culturally responsive intervention simply as 'treatment that held cultural meaning for clients' (Muñoz 2007:270).

Culture-specific knowledge, or *cultural literacy* as coined by Sue and Zane in 1987 (in Muñoz 2007:274) is acknowledged to be part of cultural competence. Even so, Munoz (2007:274) describes cultural responsiveness as a more dynamic process than cultural competence; in that it allows the therapist to go further than only culture-specific knowledge. This approach actually acknowledges what is applicable to the client, in order to engage with occupation as therapy.

2.5 THE KAWA (RIVER) MODEL

As a response in seeking a more inclusive cultural perspective of occupation, the Kawa Model is a conceptual model of practice for occupational therapy – the first to be developed in a non-Western practice (Carmody, Nolan, Chonchuir, Curry, Halligan & Robinson 2007:221; Iwama 2006:111-123; Iwama, Thomson & McDonald 2009:1125). Kawa is the Japanese word for river, the main metaphor on which the model was based by a group of Japanese occupational therapists (Iwama 2006:129; Iwama *et al.* 2009:1128).

This group of occupational therapists practicing in Japan, were increasingly struggling to associate themselves with the available conceptual models of practice – all of which

have Western origins (Iwama 2006:117; Iwama 2010:online). If they could not relate to these models on individual and personal level, they could certainly not explain the concept of occupation to their clients and colleagues (also Japanese) in a way that held value. They were therefore looking to reconcile the core concepts and aim of occupational therapy with their own contexts; and their experiential ideas about occupation (Iwama 2006:117-120; Iwama 2010:online). They undertook a qualitative study and regularly met as focus groups, with the aim to develop a new conceptual model of practice – appropriate for practice within their socio-cultural context (Iwama 2006:121). An East Asian cultural perspective was incorporated in their discourse about occupation and occupational therapy. Data was analysed according to the grounded theory proposed by Strauss and Corbin (Iwama 2006:123-125). The product of this study was, initially, a linear diagram - similar to many Western models (Iwama 2006:128); attempting to present all aspects of the life experience in an interconnected way. However, the group later felt that a metaphor from nature, is more appropriate; and the idea of the Kawa model - 'life as a river' – was born (Iwama 2006:129; Iwama *et al.* 2009:1128).

The purpose of the Kawa Model is threefold: it explains the purpose of occupational therapy, whilst providing pointers and strategies for occupational therapy intervention – within the client's specific socio-cultural context (Iwama 2006:139). Providing therapy that takes into account a client's socio-cultural context, resonates well with the idea of cultural responsiveness, as proposed by Muñoz in 2.4.

The Kawa model is quite different from typical Western rehabilitation models such as the Model of Human Occupation (MOHO) by Kielhofner (2008), and the Canadian Measure of Occupational Performance (CMOP). For example, the metaphor of 'life as a

river' allows the patient to express his views on life, himself, wellbeing and occupation (Iwama 2006:132-134; Iwama 2010:online). The 'self' is therefore seen as part of the larger picture surrounding the person – including the 'contexts that shape and influence the realities and challenges of people's day-to-day lives' (Iwama 2006:132; Iwama *et al.* 2009:1127; Turpin & Nelson 2007:323). This view is eventually in stark contrast with models such as the MOHO and CMOP, which put the self at the centre of life, and clearly illustrate the difference between collectivist and individualist worldviews (Iwama *et al.* 2009:1127). The implication of this difference in centrality of self, between the Kawa and Western models, may lay in the expectations the therapist would have for her client. Using a model developed on a Western worldview, a therapist might aspire toher patient gaining independence and autonomy (Iwama 2006:132; Iwama *et al.*2009:1127). These ideals, however, might not at all be suitable for the person not holding the Western worldview (Iwama 2009, Nelson 2007:239, Turpin & Nelson 2007:323), although it also may be argued that not agreeing to these values, is mutually exclusive to either of the worldviews. Another characteristic of the Kawa is that it is not linear and structured like most 'traditional' conceptual models in occupational therapy (Iwama *et al.* 2009:1133),which may also make it more applicable in societies outside the Western socio-cultural context .

When applying the model in practice, the main guiding principle is to allow the client's narrative to emerge (Iwama 2006:162). When comparing a client's life to a river, the therapist and client view life as a journey through time and space. The model assumes it ideal for a river to flow strongly; just like a person would want a good 'flow of life'. It acknowledges certain structures to influence and even impede the flow of the river. These structures include rocks, translating to life circumstances; driftwood – assets and liabilities; and river walls and bottom – the environment (Iwama 2006:142-155; Iwama

et al. 2009:1129). Water, or *mizu,* represents a person's life energy. Water can only be contained and not necessarily shaped; and if in a river – it is only shaped according to the river walls and bottom. The river walls and bottom – or *Torimaki*, would in this case refer to the environment – including physical and social contexts; and hints that a person is formed by his environment. Should the river walls and bottom be restricrive, any added restrictions to flow, such as rocks; would lead to a greatly diminished flow of life. Rocks – *Iwa,* represent any life circumstances with the potential to diminish the life energy or flow of life (Iwama 2006:147; Iwama *et al.* 2009:1131). Driftwood – *Ryuboku,* is considered to be transient in nature, and may include personal attributes and resources. These may refer to a person's values, character, personality, knowledge, experience, special skills; and material and immaterial assets. Driftwood may at any time during the flow of life become more relevant or evident, in positive or negative ways. (Iwama 2006:149; Iwama *et al*. 2009:1132). The purpose of occupational therapy, in the context of the Kawa, is to enhance the flow of life (Iwama 2006:151), or 'life energy, by enlarging the spaces between obstructions and enhancing general harmony between all the elements in the river' (Iwama *et al.* 2009:1133).

Iwama (2006:162) encourages the therapist to use the model in whatever approach allows the client's narrative to present itself. He identifies six steps of applying the model in practice (Iwama 2010), which are summarized in the table below (Iwama 2006:164).

Table 2.1 - Application of the Kawa model in clinical practice (Iwama 2006:164-172; Iwama 2010:online).

	SIX STEPS IN APPLYING THE KAWA MODEL IN CLINICAL PRACTICE	DETAIL ON PERFORMING THE SPECIFIC STEPS
Step 1	Appreciate the client in context ('Who is the client?')	Does the client associate with the river-metaphor? Can he see his life as a river? If the answer to these questions is *yes*, the therapist invites the client to draw a picture of his life as a river. If *no*, a different method of evaluation will be chosen.
Step 2	Clarify the context	The client is allowed to describe the different contexts of his life, as represented in the drawing of the river.
Step 3	Prioritize issues according to the client's perspective	During this step, the therapist and client discuss the *sukima,* or spaces which symbolize the opportunities for occupational therapy intervention; and prioritize all the issues mentioned.

Step 4	Assess focal points of occupational therapy intervention	In step 4, the therapist may assess certain issues with other methods and instruments, in order to gauge their weight in the client's life. The client remains the main role-player in this process, in helping the therapist to ascertain the magnitude of mentioned issues.
Step 5	Intervention	Intervention is planned and implemented.
Step 6	Evaluation	Using previous drawings of the client's river, the therapist and client can now evaluate the progress made.

The Kawa model allows the therapist to take a client centered perspective, by enquiring about the client's 'narrative or day-to-day living experience' (Iwama *et al.* 2009:1134) – a guiding factor in choosing the Kawa as the conceptual model for the current study Following this enquiry about the client's perspective on his life, the therapist can then supplement the Kawa with other tools and instruments necessary in the rehabilitation process of the individual client (Iwama *et al.* 2009:1134). Ultimately, the Kawa enables the therapist to plan a holistic intervention - suitable to the life of the client (Iwama 2006:153).

In the present study, Step 2, and possibly steps 1, 3 and 4, would be followed. Step 1 – all participants will be expected to participate in an interview according to the Kawa

model. If they do not find this easy, a three-dimensional model of a river would be used to explain the metaphor, with some practical examples. Step 2 – the participants would be allowed to explain his life as a river. Steps 3 and 4 are more directed towards intervention – which is not a part of the present study. However, should a participants steer towards prioritizing issues, with a view towards therapy; it would be incorporated in data.

Carmody *et al.*(2007) undertook a qualitative study with a grounded theory approach and case study design; in order to explore the guiding nature of the Kawa model. The study participants were two persons with multiple sclerosis, in Limerick, Ireland. Researchers engaged the participants in semi-structured interviews based on the Kawa model, upon which occupational therapy intervention plans were drawn up and intervention was delivered. Follow-up interviews were also based on the Kawa model. During analysis using a grounded theory approach, the following themes were identified. The Kawa model is regarded as a model of practice effective in guiding therapists and patients through the occupational therapy process (Carmody *et al.* 2007:226). Specific strengths of the model include that it allows the patient to share his narrative, describing his life in context; allowing the therapist to understand the patient's occupational profile including occupational performance weaknesses and strengths. It is also deemed effective in facilitating occupation-based practice, in that it helps the therapist and patient to identify problems, set goals and communicate throughout the process of intervention (Carmody *et al*. 2007:226). Using the Kawa model in practice, facilitates the forming of a therapeutic relationship between therapist and patient; whilst allowing client-centered practice to emerge and take shape (Carmody *et al.* 2007:232). Challenges identified by these same authors (Carmody *et al.* 2007:233), include the effect of researchers' preconceived ideas about

the use of the model, i.e. how the participants' rivers should be drawn; and on the participants' side: uncertainty whilst drawing the river. Nelson (2007:245) also reported uncertainty in some participants when having to draw or interpret pictures of their 'rivers'.

If models and frameworks are used by therapists to 'make sense of their clients' worlds of health and disability to guide effective and meaningful interventions', then the Kawa model provides a method of also incorporating the client's specific socio-cultural context in this process (Iwama *et al.* 2009:1134). All models are developed within specific socio-cultural contexts, and therefore have specific norms of practice. These norms may not be suitable for people from socio-cultural contexts different to that within which the model was developed, and this may lead to therapy less than ideal for the specific individual. Occupational therapy, without taking into account the culture of the patient, is regarded by Carmody *et al.* (2007:222) as possibly 'oppressive and counterproductive'. The profession has a need for models that are culturally relevant, and the Kawa model attempts to do that (Carmody *et al.* 2007:222). This viewpoint is supported by Muñoz (2007:275), who acknowledges the Kawa model as an effective tool in providing culturally responsive caring.

The Kawa model provides a unique and flexible approach to clients from different socio-cultural and non-Western backgrounds, in which their own perspective – rather than that of the specific model and its socio-culturally embedded norms – is given a voice (Iwama *et al.* 2009:1135). This is possibly because it is not linear and structured like most 'traditional' conceptual models in occupational therapy. In personal communication with Iwama (2009), he stated astutely:

> *This Kawa framework is really about working from the bottom-up; to cultivate your occupational therapy on the daily life narratives of your clients rather than foist a framework based on someone else's reality onto the unwitting client.*

Turpin and Nelson (2007:323), and Nelson (2007:251) point out that the occupational therapist working in a typical Western facility, possibly within a bio-medically oriented practice; may find it difficult to apply the Kawa model. They do, however, agree with Iwama (2006:176) on the importance of providing occupational therapy with meaning.

With regards to the application of the model in South Africa, only one literature reference could be found by the researcher. Owen (2009:23), in a book review of *The Kawa Model: Culturally Relevant Occupational Therapy* (2006), reckons that the model might be applied with success in South Africa, even if only to allow evaluation of whether our own practice is culturally relevant. This single reference does not mention the use of the model with the Sesotho speaking person, who is the main role player in the current study.

On using the model as a tool of data collection, Nelson (2007:245) reported her experience that some participants did not understand the metaphor of life as a river quite well. This lead to the tendency of pre-empting participants to provide specific answers, rather than describing their own narrative – the ultimate goal of the Kawa (Iwama *et al.* 2009:1134).

2.6 THE SESOTHO SPEAKING ADULT

Sesotho is the home language of the majority of black, African people living in the Free State Province and Lesotho. According to the 1996 and 2001 censuses (Unknown 2011:online), Sesotho is spoken by between 3 104 197 and 3 555 186 people – 7.9% of the total South African population of 44 million. Sixty-four percent (64%) of Sesotho speakers live in the Free State, the province in which the present study was conducted (Olivier 2009:online; Unknown 2011:online); making up two thirds, or approximately 1.8 million, of the 2.8 million people living in the Free State Province.

Searching for information on the mental health of Sesotho speakers, many articles were found – the majority published during the last three years (2008-2010). The most prominent article for this review, was the article of Mosotho, Louw, Calitz and Esterhuyse (2008a:35-43), from the Departments of Psychiatry and Psychology, University of the Free State. Mosotho *et al.* (2008a:35-43) conducted a study amongst Sesotho speakers, in order to describe the relation between their culture and symptoms of depression. The results indicate that three clusters of the symptoms of depression were much more prominent in the sample of one hundred (100) Sesotho speaking adults diagnosed with depression, than expected according to the DSM-IV-TR diagnostic criteria. These clusters of symptoms are found in somatic complaints, and disturbances of perception and thought processes. Mosotho *et al.* (2008a:41) concludes that the socio-cultural context should be taken into account when diagnosing and treating depression and recommend that research be done by other members of the multi-disciplinary team. In the end, they state that depression is a phenomenon with a culturally diverse presentation (Mosotho *et al.* 2008a:42). More information is available on mental health in Sesotho speakers, but only when the

findings are presented in Chapter 4, can the researcher present the information in ways relevant to the population of the present study.

2.7 CONCLUSION

This review of literature departed from a discussion about how occupational therapy practice is informed by knowledge about occupation: occupation as the essence of human living; the preferred tool of practice and a predictor and indicator of mental health and wellbeing. Culture was proposed as one of the main, but often forgotten, contexts in which occupation is performed. The Kawa model seems to provide a way of enquiring about a person's socio-cultural context in which occupations are performed, allowing the therapist to plan culturally responsive therapy. Finally, the Sesotho speaking adult is introduced to the reader – as one of the most presented inhabitants of the Free State Province.

The following chapter, Chapter 3, presents the research methodology utilized in enquiring about the occupations and socio-cultural context of the Sesotho speaking adult with mental health problems.

Chapter 3

Research Methodology

3.1 INTRODUCTION

The review of literature in Chapter 2, confirmed the lack of guidelines available with regards to culturally relevant OT practice for the population of patients at The Clinics. The chapter explained how the 'being' and 'doing' (the socio-cultural context and occupations) of a person has to be considered in occupational therapy intervention, in order to provide therapy that is meaningful to the person. The Kawa model was proposed and described as a conceptual model of practice reconcilable with this study.

Already in the first chapter, the research problem was stated as a need for more information on the occupations and socio-cultural context of the Sesotho patients attending the group therapy program at The Clinics. In the following chapter (3), the planned framework for answering the research question in this study, will be described in detail. The rationale behind the selection of the qualitative research approach, and the collective case study as strategy of inquiry, will be explained. The research methods and process, including data collection, analysis and interpretation, will then be detailed. A description of the research population and sample, as well as measures taken to ensure rigor and ethical conduct will conclude the chapter.

3.2 RESEARCH APPROACH AND STUDY DESIGN

The research approach and study design for the present study will be discussed under four headings: the philosophical background of this study; research design; strategies of inquiry and research methods (Creswell 2009:5).

3.2.1 Ontological point of departure and philosophical background

The very inception of this study; its core concern, was inspired by a question posed by Yerxa (2009:492):

> *Can we truly help another human being without knowing what he or she experiences..?*

It seemed the researcher in the present study, by asking the latter question in her role as occupational therapist, was aiming for 'best practice' in her daily job as an occupational therapist. In the search for literature on culturally relevant OT practice for the population at The Clinic, many references to 'best practice' were found. Blair and Robertson (2005:269-270) identified three approaches to support best practice: evidence-based practice (EBP), reflective practice and reflexive practice.

Evidence-based practice would traditionally require a positivistic approach to research, aiming to provide strict guidelines for practice, gained from quantitative data. In *reflective practice*, rooted in interpretivism, a practitioner would incorporate her own understanding and experience of practice. *Reflexive practice* would rely on critical thinking in the study, about what is assumed to be the knowledge about practice, by means of discourse analysis (Blair & Robertson 2005:270).

Holding Yerxa's question (2009:492) in mind, it seems that traditional evidence based practice (EBP) – in its positivistic nature – might not be sufficient or appropriate in enquiring about the occupations and socio-cultural context of the population at The Clinic. While EBP research questions the 'truth' about what kind of practice is effective and what kind not; it seemed that Yerxa has asked a question that would entail much more than a singular investigation that 'measured' an aspect of effective practice. Yerxa's question implies complex answers to a complex question that cannot be pursued with linear approaches. At this point, it was sufficient to acknowledge that

reflective practice (i.e. reflection by the therapist) and reflexive practice (from a critical theory point of view) was the background to questioning daily practice at The Clinic; and that EBP (not in its positivistic nature) would be the aim in the researcher's quest for best practice.

This study argued that its ontology lies in constructivism, which implies that there is not one *single* truth, and that humans create their own reality from their their social and cultural contexts (Carpenter & Suto 2008:23; Creswell 2009:8). The latter implication allowed the present study to 'seek to understand the context…of participants through visiting this context and gathering information personally' (Creswell 2009:8).

3.2.2 Research design

With the study aiming to generate an understanding of the participant's experience of his/her occupations and socio-cultural context, it seems that some level of 'evidence' was required. Even though EBP is traditionally based on quantitative research from a positivist worldview, qualitative research is increasingly represented in the EBP discourse (Carpenter & Suto 2008:ix; Taylor 2009:218), perhaps due to three unique traits of qualitative research as opposed to quantitative research (Whiteford 2005:42). The first trait identified by Whiteford (2005:42) is that qualitative research methods are context specific, enquiring about the 'life world' of participants, including the contextual factors (e.g. culture) impacting on occupation. The second trait would be the value of having an 'insider's perspective' as part of the data used to answer a research question, and the third, the iterative nature of the qualitative approach ('allowing for unexpected results to emerge'). Finally, qualitative research also provides the opportunity to do an interpretive inquiry, and allow a researcher to generate a deeper understanding of how meaning regarding a certain phenomenon is constructed by the participants (Creswell 2009:176; Ritchie, Lewis & Elam 2003:82).

Two epistemological stances to qualitative research are widely acknowledged (Fossey, Harvey, McDermott & Davidson 2002:718; Henning *et al.* 2004:17; Klein & Myers 1999:67-94): the critical and interpretive paradigms. The critical paradigm, originating from feminism, Marxism and psycho-analysis; privileges the voices of stakeholders and often uses collaborative types of research as method, e.g. action research (which could also be situated in the interpretive paradigm though). The interpretive paradigm has its origins in phenomenology and hermeneutics; regards the human being as a social being that construct his own meaning of his life world; and listens to the voice of the participant, rather than that of the researcher; with the aim of *understanding*.

In the absence of quantifiable variables (the positivist approach), or social critique (the critical approach), the interpretive approach was chosen as the most appropriate for this study. In interpretivism, 'absolute truths' and 'laws of behaviour' are not the focus, but rather a better understanding of local contexts (Willis 2008:67). This approach also allowed the exploration of phenomena, and the generation of ideas and theories (Snape & Spencer 2003:16), and was set as background for this study.

In summary: this study made use of a qualitative study design with an interpretive approach.

3.2.3 Strategies of inquiry

Sifting through strategies of inquiry within the interpretive paradigm, the researcher was left with two options: the phenomenological and case studies. The phenomenological study would not be suitable for this study, since it would aim to describe *the lived experience* of a single phenomenon (Creswell 2009:13). The collective case study, on the other hand, would allow the focus to fall on the complexities of a small number of cases (Creswell 2009:13), and was thus regarded as the ideal strategy

to gain an understanding of the occupations and socio-cultural context of the Sesotho patient at The Clinic.

Whether the qualitative case study is a strategy of inquiry or a 'choice of what will be studied' (Stake 2008:119), is an ongoing dispute between different authors (Willis 2008:210) within the discourse of qualitative research.

On the one hand, authors see the case study as a strategy of inquiry: it provides direction for procedures to be used within the research design (Creswell 2009:11). Authors referring to the case study as per this definition, include Creswell (2009:13), Willis (2008:210), Denzin and Lincoln (2005:25), Fouchè (2005a:272), Leedy and Ormrod (2005:135), and Bowling (1997:359 & 386).

On the other hand, Stake (2008:119) and Henning *et al.*(2004:40) hold the opinion that the case study is rather a 'choice of what will be studied' than a strategy of inquiry. The question of 'What is this study a case of?' (Henning *et al.* 2004:42) needs to be asked; upon which a researcher would identify boundaries to fence off the case.

The researcher agreed with the above mentioned authors (Henning and Stake) on the fact that the case should be described as a bounded system with shared characteristics. However, security was also found in using the case study as a strategy of inquiry, which provided some direction for the methods of data collection (Willis 2008:215-217) and writing of the dissertation (Leedy & Ormrod 2005:136).

In spite of the dispute described above, there are many other characteristics of the case study, described by the same authors, which further highlights the appropriateness thereof for studying the research question for the present study. These characteristics are described in the following paragraph.

The collective case study, as a group of people studied as a "bounded system" (Henning *et al.* 2004:32); afforded the opportunity to describe the population without having to distinguish between context and phenomena (Bowling 1997:360). It allows more than one perspective to be considered, leading to a better understanding and holistic, in-depth description of the small group of cases (Bowling 1997:360; Henning *et al.* 2004:41; Lewis 2003:52&76); including what is "common and particular" about the case (Stake 2008:125).

The collective case study is valuable, in that it describes a small group of cases with a large amount of diverse information; as opposed the quantitative style where a large group is described with a small amount of information (Willis 2008:105). Qualitative case studies are also appropriate to answer 'how' and 'why' questions (Willis 2008:211), and to generate context-dependent information (Willis 2008:218). Willis (2008:218) refers to context in a way very applicable to the present study:

> *If understanding the context is very important when considering the application of study findings to other settings, the rich and diverse range of data provided is an important and desirable feature of the qualitative case study.*

When writing the dissertation, the case researcher would aim to describe the case sufficiently to allow the reader to draw his own conclusions (Stake 2008:129), limiting the responsibility of the researcher to generalize. Method triangulation (Stake 2008:133), as a process of using multiple methods to study the topic, is therefore an integral part of the case study, adding rigor (cf. 3.5) to its findings. In the present study,

semi-structured interviews were supplemented with a focus group, as a means of method triangulation.

Qualitative research is emergent in nature, a characteristic which allows a researcher to plan further methods of data collection as the study progresses (Fossey *et al.* 2002:723). This characteristic is reconcilable with the case study as a strategy of inquiry, since it requires multiple methods of data collection (Stake 2008:133). In the present study, the emerging nature of qualitative research was seen, in that the semi-structured interviews were followed by a focus group, to allow another opportunity to gain information.

With the case study now established as the strategy of inquiry for this study, appropriate research methods will be described in the following section.

3.2.4 Research methods

The following paragraphs include detailed descriptions of the research methods relating to this study, including piloting, data collection, analysis and interpretation (Creswell 2009:15).

Initially, individual interviews was planned as the first method of data collection in this inquiry. After the analysis of data, the emerging nature of qualitative research Fossey *et al.* 2002:723; Leedy & Ormrod 2005:143) allowed a second method of data collection to be conducted, and a focus group was held in order to gain more information on the socio-cultural context of the sample. In addition, the combination of individual interviews and focus groups is regarded as a very effective way of collecting rich data (Lewis 2003:60).

For ease of reading, the research methods for the individual interviews and focus group, are described in two separate sections, 3.3 (Individual interviews) and 3.4 (Focus group). A summary of core information is provided in Figure 3.1.

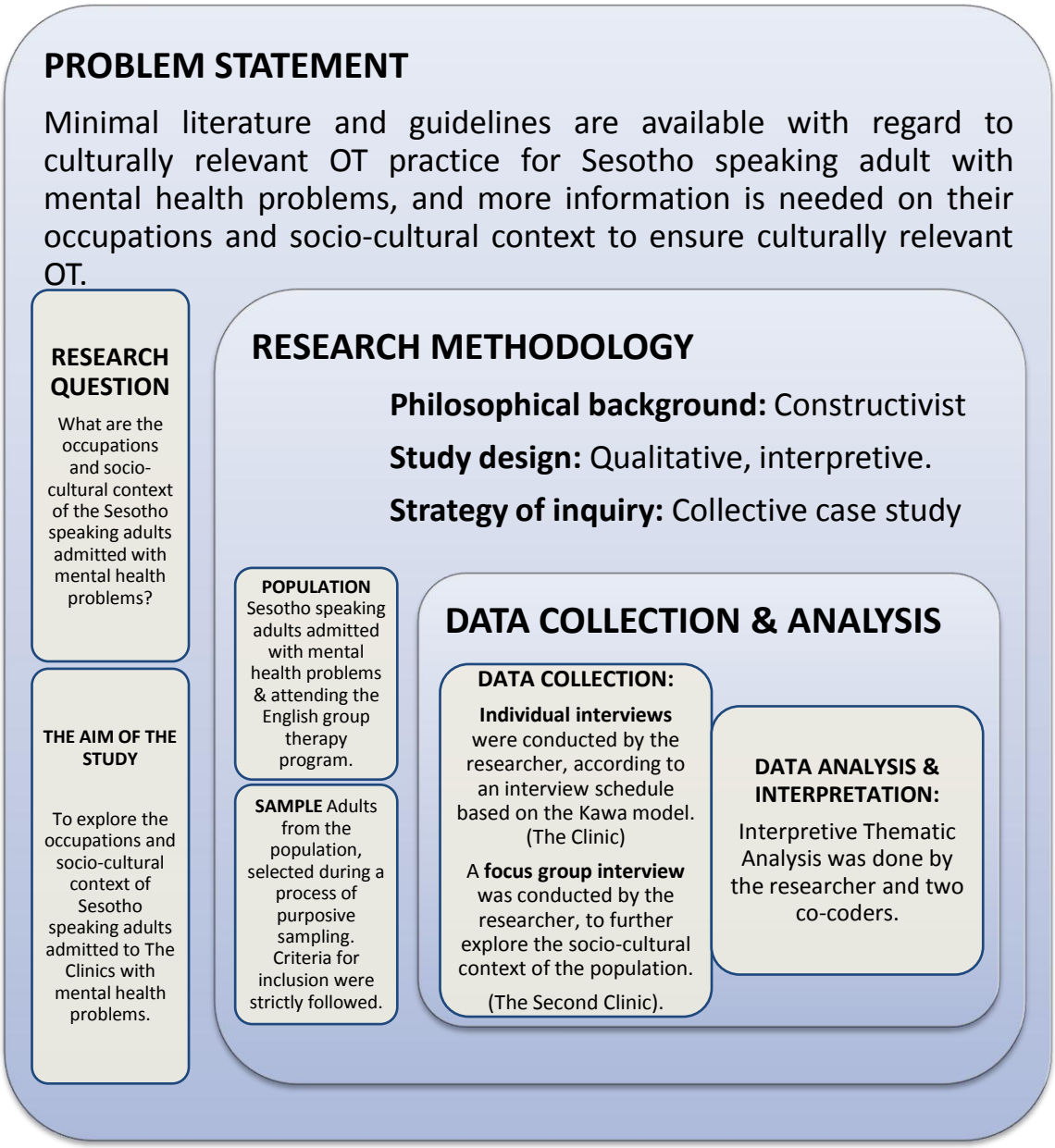


Figure 3.1 - Schematic presentation of research methodology

3.3 INDIVIDUAL INTERVIEWS

The following paragraphs describe the population and sample, and process of data collection for the first phase of the study (i.e. the individual interviews based on the Kawa model).

3.3.1 Research population

The population is the larger group, from which the sample of participants is selected (Bailey 1997:83; Carpenter & Suto 2008:77). In qualitative research, it is imperative to include participants who can contribute in answering the research question (Carpenter & Suto 2008:77); in the sample. Therefore, in order to allow for proper selection of the sample from the population it is important to have ample information about the population (Creswell 2009:178; Strydom & Delport 2005:329).

The population that was focused on in this study, consisted of patients attending the English group therapy program at The Clinic. These patients have been admitted to The Clinic by psychiatrists, for psychiatric care and attendance of the group therapy program. Adult male and female persons, suffering from a range of mental health conditions, were represented. These conditions include mood, anxiety, somatoform, sleep and personality disorders. Substance-related and impulse-control disorders, as well as schizophrenia and other psychotic disorders are also seen in the population (Barlow & Durand 2009:vii). However, only patients able to coherently participate were included in the group therapy program. (Should this not be the case, they would receive individual treatment, as decided by the attending psychiatrists, therapists and the group therapy coordinator.) The majority of patients were mother tongue Sesotho speakers, although Setswana, Afrikaans and IsiXhosa speakers were also presented in the minority. Most patients were employed, many of them in the public sector.

With regards to the size of the population available for inclusion in the process of sampling, the researcher requested the number of admissions over the twelve (12) months prior to the writing of the research proposal. This number was not officially available. However, an interview with the Group Program coordinator at The Clinic, confirmed the following details which may have had a direct effect on the size of the population and sample (Gűldenpfennig 2009):

- The approximate number of admissions spread over every period of fourteen days, were fifteen (15) to thirty five (35) patients.
- With regards to the amount of admissions, Gűldenpfennig (2009) confirmed that admissions at The Clinic differed from week to week, that seasons had no effect on the amount of admissions and that the only time of year the group therapy program were temporarily terminated was during the Christmas season. She added that school holidays were sometimes more quiet with regards to the number of patient admissions.

Based on the information provided above, it was expected to have at least twelve (12) possible candidates for participation every week.

3.3.2 Sampling

The sample refers to the set of participants drawn from the larger population (cf. 3.3.1); by means of a specific method of sampling. The sample would share some aspects with the larger population, although it would not necessarily represent the population in the statistical sense, but rather in a symbolic or characteristic way (Carpenter & Suto 2008:79; Strydom 2005b:192-194; Ritchie, Lewis & Elam 2003:83).

Sampling techniques are very specific, and are employed in accordance with the purpose and methodology of research. Non-probability sampling techniques are the

methods of choice in qualitative studies such as this one. Purposive, or criterion based sampling as described by Ritchie, Lewis and Elam (2003:107), is one of these techniques and have been selected to deduct the sample from the larger population at The Clinic, according to certain criteria (cf. 3.3.2.1). This method allowed the inclusion of cases according to their potential to 'contribute to an understanding of the phenomena of interest' (Carpenter & Suto 2008:78 & 80; Strydom & Delport 2005:328).

In this study, the purposive sample (cf. 3.3.2.2) had to consist of a number of Sesotho speaking male and female adults, suffering with mental health conditions and attending the English group therapy program at The Clinic.

3.3.2.1 Selection criteria

The following selection criteria were compiled after careful consideration of the population at The Clinic, as well as the notes on sampling made in 3.3.2. The aim of the selection criteria for this study; was to exclude any cases 'outside the scope of (the) enquiry' (Ritchie, Lewis & Elam 2003:87) and include cases with the potential to complement the enquiry (Henning *et al.* 2004:71). These criteria have been chosen in order to allow 'symbolic representation' (Ritchie, Lewis & Elam 2003:83) of the population, in other words to allow the character of the population to be presented by 'typical cases' (Carpenter & Suto 2008:78). Even within these boundaries, a sample as diverse as possible, would allow the study to describe the occupations and socio-cultural context of the population more effectively; and the researcher therefore limited the number of criteria.

INCLUSION CRITERIA

- Patients compliant with the criteria for attendance of the short term, psychosocial inpatient English group therapy program at The Clinic. These criteria include:
    - Patients able to coherently participate in the group therapy program, referring to their ability to communicate in English and be apsychotic.
    - Patients not portraying extreme behaviour, i.e. uncontrollable crying, aggressive outbursts.
    - No indication from the psychiatrist that the patient is prohibited from attending the program.
- Patients reporting Sesotho to be their mother tongue or first language.
- Adults of working age (18-60 years).
- Patients who have agreed to sign the informed consent form.

EXCLUSION CRITERIA

- Patients whose referring psychiatrist or psychologist prohibits them from participation to the study, due to being mentally or emotionally not stable enough to be exposed to an interview with the researcher.
- Patients who are not attending the group therapy program; due to being mentally or emotionally not stable enough to participate productively.
- Patients who are unable to or choose not to participate in an English interview (i.e. translation services will not be offered).
- Patients who have participated in the pilot study (i.e. no participant would be required or allowed to participate in the pilot and main studies).

OTHER CRITERIA

Equal numbers of male and female participants were interviewed.

3.3.2.2 The sample

A sample in a qualitative study may consist of ten (10) participants or fewer, provided that the principle of saturation is followed (Polit & Beck 2006:273). This principle requires that the data collection process (i.e. interviews), proceed until no new categories of information are obtained and data is 'saturated' (Carpenter & Suto 2008:80; Strydom & Delport 2005:329). Strydom and Delport (2005:328) support this principle and even suggest that the size of a sample in qualitative research can only be determined once the study has commenced.

Generalizability and representativeness, as used in quantitative research, should not be important factors in qualitative research (Carpenter & Suto 2008:80; Polit & Beck 2006:269). However, in this study, which had the purpose of describing the occupations and socio-cultural context of a specific population; the principle of saturation was followed, to increase transferability (Carpenter & Suto 2008:80; Flick 2002:183; Ritchie, Lewis & Elam 2003:83). Transferability allows readers of qualitative research data to apply the findings and conclusions to similar populations (Polit & Beck 2006:44).

Following the principle of saturation, required that interviewing continued until no significantly new information was gathered. The size of the sample could therefore not be determined prior to the study. In the end, twelve (12) participants have been interviewed, six (6) male and six (6) female. The interviews conducted during the pilot study, is included in this number; since there were no significant changes made to the data collection procedure.

3.3.3 The pilot study

The pilot study was regarded as the 'dress rehearsal for the main investigation' (Strydom 2005c:206). Its' purpose included the identification of possible problems with the main study and allowed the researcher to gain confidence in the specific

interviewing method. The pilot study was conducted at The Clinic with patients attending the English group therapy program.

The selection of participants for the pilot study was done in a similar way to the selection of the sample for the main study i.e. according to the selection criteria (cf. 3.3.2.1.) Four (4) patients were taken through the planned process of the research. During and upon completion of the pilot study, the researcher had to be sensitive for the following aspects:

- questions or comments which proved to be confusing during completion of the interview;
- skills and techniques to be used or avoided during the interview;
- practical matters which may prove problematic once the main study is conducted (e.g. venue, correct timing, interruption of the clinic program).

Following the first three (3) interviews, the study leader provided the researcher with valuable pointers on improved interviewing skills. It was also decided that a three dimensional (3D) model of a river would have to be made available for use during the interviews, in order to use should a participant struggle to grasp the concept of seeing his/her 'life as a river' (Appendix B). In essence, the methodology remained the same, since no interview questions have been added or excluded.

Data obtained from a pilot study maybe included in the final findings of the study if no significant changes to methodology have been made following the pilot study (Arthur & Nazroo 2003:135). Data from this study was thus included in the process of data analysis. However, no participants participated in the interview more than once; or in the individual interview and focus group interview.

3.3.4 Data collection

The ultimate aim in a case study design is to do an in-depth investigation of the case, and collect sufficient data to allow the researcher to describe the case comprehensively. To allow this, multiple methods of data collection are used, and these may include interviews, documents, observations and archived records (Fouchè2005a:272; Leedy & Ormrod 2005:135). Similarly, Henning *et al.*(2004:42) holds the view that should a researcher need multiple sources of information to describe a case properly, it warrants the use of a case study design and at the same time confirms design validity.

Prior to planning the methods of data collection to be used in the present study, the researcher had to identify the kind of data needed to answer the research question (Creswell 2009:178). It was identified as: information on the occupations and socio-cultural context of the Sesotho speaking patients at The Clinic.

Interviews are indicated as appropriate for use within the interpretive theoretical framework in research, and therefore in the present study (Carpenter & Suto 2008:83). Hence, semi-structured interviews were conducted by the researcher with individual participants; according to an interview schedule mainly based on the Kawa model (Iwama 2005a). Interviews were conducted during February and March 2011. The interview schedule (Appendix B) started out with some basic questions on age, job and marital status; proceeding to life-roles. This afforded the interviewer the opportunity to establish some rapport with the participant; and to get to know the participant sufficiently to conduct the rest of the interview with more insight and sensitivity towards the participant; as well as designing case profiles (cf. 3.3.6) (Flick 2002:186). Following these, were questions on the participant's need for specific topics to be handled in the group therapy program. These would indicate some self-identified problematic areas in life. Concluding this first part of the interview, were some

questions on the cultural background of patients. The final, and main part of the interview consisted of the interviewer providing the participant with the opportunity to describe his/her life; metaphorically as a river, according to the Kawa model (Iwama2006:142).

This technique guided the interview towards an enquiry on the participant's daily life prior to admission, i.e. his/her occupations within his/her socio-cultural context. Participants were afforded the opportunity to describe their life circumstances; social and physical environments, as well as their assets, liabilities and responsibilities; by using the Kawa model (Iwama 2006:143).

Appendix B contains the interview schedule, providing the outline of questions that were included in the interview. The following paragraphs described the practical matters regarding the interview, i.e. arranging the interview, the venue, recording the interview, as well as gaining consent from participants. Pointers for efficient interviewing are also described.

3.3.4.1 The interviewing process (Legard, Keenan & Ward 2003:138-169).

The interviewing process, with an average duration of forty-five (45) minutes, was structured as follows:

<u>A few days before the interview</u>:

- Staff at The Clinic (the group therapy coordinator specifically), were requested to inform patients about the possibility of being invited to participate in the study.
- Following this, the researcher obtained a list from the coordinator, with the names of patients who could be invited for participation. She then personally and purposively invited patients from this list to participate in the study; and arranged appointments with those willing to attend interviews.

- Information documents, with attached form for informed consent (Appendix C), were provided to patients who made appointments with the researcher.

The day of the interview:

- The consultation room was set-up prior to every first interview of the day.
- The room was well-lit, with good ventilation; and cooling or heating as necessary.
- A table with two chairs was arranged to allow the researcher to sit at a 90° angle to the patient.
- The researcher had the following equipment at hand:
- Two digital recorders with charged batteries and a set of extra batteries (Legard *et al.* 2003:166).
- A watch, to keep track of time during the interview – even though no formal time restriction would be set.
- Water for both participant and researcher.
- A box of tissues, placed discreetly out of sight, in case any participant became emotional.
- A notepad and pens, used by the researcher to keep field-notes.
- Paper and pens/pencils, to be used for drawing by the researcher and participant during the interview.
- Extra copies of the informed consent form.
- A copy of the interview schedule (Appendix B)
- The following notice was placed on the closed door:

Please do not disturb, interview in progress.

The interview:

- The participant was greeted and invited into the designated consultation room at The Clinic.
- The interview process was explained, including the reasons for using the digital recorder and writing field notes (Henning *et al.* 2004:75).
- The process of informed consent between researcher and participant was completed, and the participant reminded that information gained during the interview would be treated confidentially (cf. 3.7.5).
- Up to now, and throughout the basic questions in the interview schedule, the researcher remains aware of the participant's possible need to be reassured about this seemingly abnormal situation of engaging in an interview with a stranger. It is important to establish a level of trust, in order to allow the participant to participate successfully and with ease.
- The researcher initiated the interview by posing the first, most basic questions in the interview schedule, and then proceeded with the Kawa interview according to the interview schedule (Appendix B).
- During and after the interview, the researcher took notes, including descriptive and reflective notes.
- Upon completion of the interview, the researcher invited the participant to ask any questions should he/she wanted to; then thanked the patient for participation and greeted him/her.

The researcher empowered herself with regards to efficient interviewing, by studying literature on interviewing (Greeff 2005:286-313; Legard *et al.* 2003:161-165), and using

'Qualitative Interviewing: the art of hearing data' by Rubin and Rubin (Rubin & Rubin 1995) as guidance throughout. The researcher has also been trained in interviewing during her undergraduate studies, and interviews people often in her current practice as occupational therapist in a psychiatric hospital. The pilot study, and feedback from the study leaders, also served as a useful learning experience.

Being a qualified occupational therapist, familiar with the Kawa model (Iwama 2006), the researcher was allowed to ask probing questions during the interview – provided it was to require the participant to elaborate on answers linking to occupations and socio-cultural context (i.e. answers relating to work, sleep, social functioning, leisure and personal management). Five pointers by Rubin & Rubin (2005:352), have been used during prompting, and has been summarized in Table 3.1 below.

Table 3.1 - Five pointers for prompting during interviewing (Rubin & Rubin 2005:352)

PROMPT	EXAMPLE OF THE PROMPT
Encourage the participant to elaborate	"Could you tell me more about…?"
Allow the participant to continue	Non-verbal cues i.e. nod the head; or say "And then…?"
Provide the opportunity to clarify	"So what you were saying is…" "Could you explain…..to me?"
Demonstrate the researcher's attention to the conversation	"That's really interesting" (Carpenter & Suto 2008:84).
Create contrast	"Even though you said earlier that you did not like to…"

The pilot study (cf. 3.3.3) also served as an opportunity to practice interviewing skills, and following the first three interviews, the study leaders guided the researcher in conducting more efficient interviews.

3.3.5 Data management

Digital recordings were made of all interviews, by means of two digital recorders, allowing the researcher to also have back-up copies. Verbatim transcriptions were typed by the researcher and hard copies were printed for use during the analysis of data. (These hard copies were stored where nobody but the researcher has access to it).

Field notes and figures made during interviews, as well as all the forms completed, were also attached to these hard copies, in order to keep al the information regarding one participant, together (Creswell 2009:182-183; Flick 2002:166). All notes were marked with the participant numbers, instead of names. However, a list of names, with dates and times of interviews; were kept in a safe place by the researcher should hospital staff (i.e. doctors, psychologists) have any queries or complaints.

3.3.6 Data analysis and interpretation

Data analysis is the process of 'making sense out of (…) data' Creswell (2009:183), and this view provided the background to the process of analysis and interpretation in this study. The researcher did not want to merely report *data*, but rather *make sense of data* in a way that would answer the research question: what are the occupations and socio-cultural context of the Sesotho speaking adult at The Clinic?

Data was collected by means of individual semi-structured interviews according to an interview schedule based on the Kawa model. The first part of the interview included

basic questions similar to the typical demographical questionnaire; and was therefore recorded on paper and not digitally. This information was analysed by the researcher and not by co-coders; and allowed the researcher to describe each participant, and therefore the whole sample, in details fitting the research question, such as age, sex and employment status (Creswell 2009:184). Flick (2002:186) refers to this description of each participant as the 'case profile'; a term adopted for this study.

Data collected during the part of the interview based on the Kawa model (Iwama 2006), was analyzed according to the *interpretive thematic analysis approach*. This approach has been identified as appropriate for this study, since it would enable the researcher to do 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).

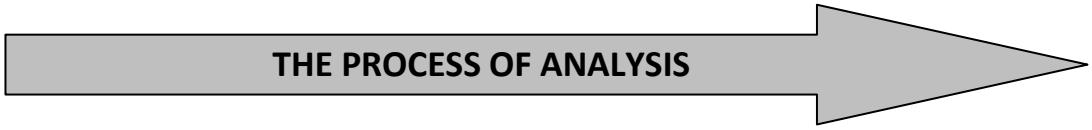
All the sources consulted by the researcher, provide similar guidelines for qualitative analysis and specifically interpretive thematic analysis, even though terminology differs slightly (Carpenter & Suto 2008:115; Creswell 2009:186; Creswell 2012:237 & 238;Polit & Beck 2006:398; Ritchie, Spencer & O'Connor 2003:237; Saldaña 2009:3). All these authors also comment on the tendency of qualitative researchers to remain vague on the process of analysis they followed. In addition, Polit & Beck (2006:418) warn against the 'blending of traditions' when doing qualitative analysis, especially when using specific traditions such as the Van Manen, Glaser and Strauss, and Colaizzi methods. The researcher was convinced that the process of analysis in the present study had to be clearly defined, and chose to use the steps of analysis as proposed by Creswell (2009:184).

However, the guidelines set by the other authors mentioned above (Carpenter & Suto 2008:115; Polit & Beck 2006:398; Ritchie *et al.* 2003:219 & 237; Saldaña 2009:3),

provided the researcher with valuable background-information in choosing and performing the analysis approach of Creswell (2009:184). These guidelines have therefore been included in Table 3.2 below, which aims to put guidelines next to each other. Tabulating these guidelines, proved to the researcher that they complimented, rather than contradicted, each other.

Table 3.2 follows on page 62

Table 3.2 - Schematic presentation of guidelines for analysis of qualitative data, compiled by M.E. Vermaak (Authors: Carpenter & Suto 2008; Polit & Beck 2006; Ritchie, Spencer & O'Connor 2003; Saldaña 2009).



Carpenter & Suto (2008)	Data reduction			Data display		Conclusion drawing
Creswell (2009& 2012)	Organize & Prepare data for analysis	Read through data in order to get a 'feel' for the general ideas.	Start with coding	Generate categories & themes.	Presentation of data (i.e. narrative, metaphorically; visually)	Interpret data by asking: 'What were the lessons learned?'
De Vos (2005a:337)	Managing & organizing data	Read through data in order to get a 'feel' for the general ideas.	Analyze data by applying codes to recurring, or significant ideas	Generate categories that externally similar; but internally different (2005a:338).	Generate themes	Explore patterns and links between themes
Flick (2002)	Case profile (description of each participant)	Open coding	Selective coding	Generate categories & themes.	Develop a thematic structure	
Ritchie, Spencer & O'Connor (2003)	Labeling of data			Sorting by theme		Summarizing & Synthesizing
Polit & Beck (2006)	Comprehending	Synthesizing		Theorizing		Re-contextualizing

Finally, the analysis approach as proposed by Creswell (2009:184) and used in the present study, is set out step-by-step in Figure 3.2 below. Two inclusions have been made from other authors, in order to streamline the analysis approach, without making fundamental changes. Flick's (2002:186) case profile was added as step two (2); allowing the author to describe each participant and the group of participants in a way that further answers the research question. Also, Carpenter and Suto's (2008:115) recommendation to highlight 'units of meaning' prior to coding, has been included as step four (4).

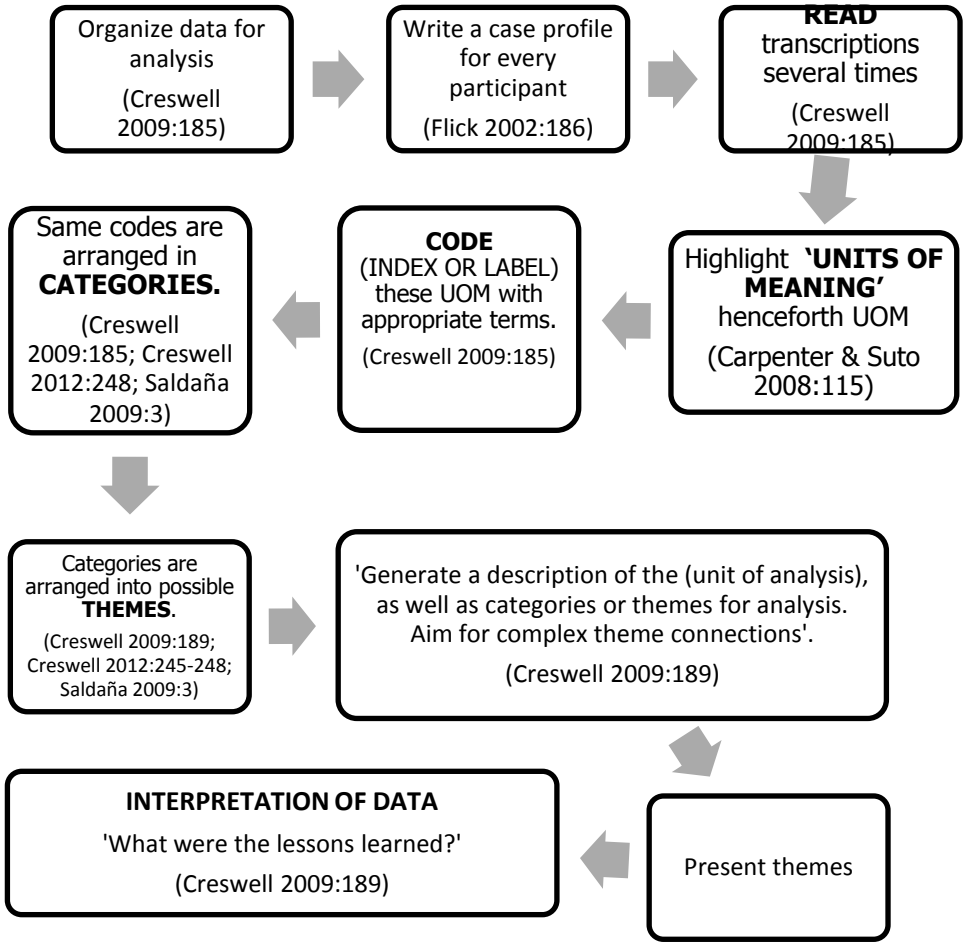


Figure 3.2 - The process of data analysis to be followed in this study (compiled by M.E. Vermaak)

With codes being the smallest unit in the process of analysis, it was regarded as the starting point to the process, and the researcher consulted Saldaña's 'The Coding Manual for Qualitative Researchers' (2009). He describes codes as the smallest units in the process of analysis: a word or short phrase which summarizes the text; with categories (and sub-categories if necessary) made up of codes; and themes consisting of several categories grouped together (Saldaña 2009:3, 8-12). In summary: codes are grouped into categories and sub-categories; which are then grouped into themes.

Several types of coding are described by Saldaña (2009), and he advises qualitative researchers to employ more than one method of coding during analysis. The researcher identified at least six coding methods appropriate to the present study, from Saldaña's book (2009); including *a priori, descriptive, in vivo, emotion, values and provisional coding*.

A priori coding is based on the conceptual framework or paradigm of a study; i.e. the Kawa model. It allows the researcher to identify codes prior to analysis, in order to answer the relevant research question (Saldaña 2009:49). *Descriptive coding* summarizes the 'topic' of a unit of analysis, and is therefore a basic kind of coding involved in most studies (Saldaña 2009:70). *In vivo* coding allows a researcher to use the voice of the participant, quoting directly from interviews; furthering the potential for thick description during the writing of the research report (Creswell 2009: 184, 189 & 193; Saldaña 2009:74). *Emotion coding* allows the analyst to code specific emotions (Saldaña 2009:86), with *values coding* highlighting a person's attitudes, beliefs and values (Saldaña 2009:91). *Provisional coding* is done when the researcher starts out with a category of codes, according to literature or the research question, i.e. occupations and socio-cultural context (Saldaña 2009:120).

The above methods of coding included a combination of predetermined and emerging codes. Predetermined codes had to do with occupations (i.e. sleep, work, social participation, recreation and personal management), which were substantial in the description of the occupations of participants. The Kawa concepts (cf. 2.5) were also used as predetermined codes, allowing the researcher to present the codes by means of the metaphor of life as a river. Emerging codes were based on information emerging during the process of coding (Creswell 2009:187), especially in emotion, value, in vivo and descriptive coding.

Referring to the last step of analysis as depicted in Figure 3.2, the researcher furthered the interpretive process by doing the following: comparing information with existing theories or literature (i.e. theoretic triangulation) and looking for new questions to be asked (Creswell 2009:189).

Two (2) co-coders, familiar with the analysis process of qualitative research, were appointed to go through the same process of analysis and coding as described above. This was important in ensuring maximum rigor (cf. 3.5), by providing objective analysis of the same data analyzed by the researcher (Creswell 2009:191, Saldaña 2009:27). Both co-coders were qualified occupational therapists with post-graduate qualifications, working at an academic institution.

3.4 FOCUS GROUP INTERVIEW

The following paragraphs describe the population and sample and process of data collection for the second phase of the study (i.e. the focus group interview conducted at The Second Clinic, in August 2011). The reader is reminded that most references to literature were made in the paragraphs on the individual interviews (cf. 3.3). However, references specifically relating to the focus group, will be made as appropriate.

3.4.1 Research population

The researcher would have performed a focus group interview at The Clinic (the venue for completing the first phase of data collection), compiling a sample from a similar population than the one in which the interviews were conducted, in February 2011. However, due to unforeseen circumstances, this could not be arranged and another, similar population had to be considered. The Second Clinic was then considered as possibility, since it had a population and English group therapy program similar to that of The Clinic (cf. 3.3.1).

The directors at The Second Clinic gave consent for the focus group interview to be conducted, and the researches process proceeded as planned. The researcher submitted the necessary paperwork to the Ethics Committee of the Faculty of Health Sciences, University of the Free State. Information documents and forms to sign informed consent, were also designed (Appendix D).

The research population at The Second Clinic, consisted of adult Sesotho speaking males and females, admitted by psychiatrists, for psychiatric care and attendance of the English group therapy program.

3.4.2 Sampling

As with the individual interviews (cf. 3.3.2.2), the purposive sample had to consist of Sesotho speaking male and female adults, suffering with mental health conditions and attending the English group therapy program at The Second Clinic.

3.4.2.1 Selection criteria

The selection criteria for individual interviews, were used to compile the sample for participation in the focus group (cf. 3.3.2.2).

3.4.2.2 The sample

The ideal size for a focus group, is indicated by literature to be between six and ten participants (Carpenter & Suto 2008:87; Greeff 2005:305).

The actual sample of participants in the focus group, consisted of eight persons: three male and four female. The sample was similar to the one participating in the individual interviews, with one exception: equal numbers of male and female persons could not be recruited for participation.

3.4.3 Data collection

Initially, individual interviews were the method of choice for this study. However, following the analysis of data, the need for extra information on the socio-cultural context of the population was identified. In order to collect sufficient data to allow the researcher to describe the case comprehensively, the focus group method was chosen for further data collection. This proved to fit in with many authors' view that the case study lends itself to the use of multiple methods of data collection (Fouchè 2005a:272; Henning *et al.* 2004:42; Leedy & Ormrod 2005:135).

A focus group consists of six (6) to ten (10) participants, who meet once off for a discussion of a specific topic (Lewis 2003:173). This kind of group interview allow the group dynamics to contribute to its success in generating data: group members can bounce ideas off each other and thus elaborate on their opinions, as well as contradict each others' opinions (Lewis 2003: 58).

Focus groups are regarded as appropriate for use within the interpretive theoretical framework in research, and therefore in the present study (Carpenter & Suto 2008:83). As mentioned before, it is ideal to follow up individual interviews with a focus group

interview, to allow the researcher to elaborate on findings from said interviews (Lewis 2003:59).

With regards to facilitation of the focus group, Carpenter and Suto (2008:86) recommend that the facilitator follow the same guidelines (cf. 3.3.4.1) used for individual interviewing (Greeff 2005:286-313; Legard *et al.* 2003:161-165). Greeff (2005:302) encourages researchers to conduct focus groups by themselves, especially if they are experienced in group facilitation and involved in the analysis of data. The researcher in the present study deals with group facilitation on a daily basis; is involved in the analysis of data for the study, and therefore conducted the focus group.

The following paragraphs describe the practical matters regarding the interview, i.e. arranging the interview, the venue, recording the interview, as well as gaining consent from participants.

3.4.3.1 The focus group

The process of arranging and conducting the focus group, is described in the following paragraphs.

A few days before the focus group:

- Staff at The Second Clinic (the English group therapist specifically), were requested to inform patients about the possibility of being invited to participate in the study.
- Following this, the researcher obtained a list from the English group therapist, with the names of patients who could be invited for participation. She then personally invited all patients from this list to participate in the study; and arranged the appointment with those willing to attend the focus group.

- Information documents, with attached form for informed consent (Appendix D), were provided to patients who agreed to participate.

The day of the focus group:

- The consultation room was set-up. The room was well-lit, with good ventilation; and a comfortable temperature. Chairs were seated around a round table, as participants were used to this way of seating in their daily group sessions in the same venue.
- The researcher had the following equipment at hand:
- Two digital recorders with charged batteries and a set of extra batteries (Legard *et al.* 2003:166).
- A watch, to keep track of time during the interview – even though no formal time restriction would be set.
- Water for all participants and the researcher.
- A box of tissues, placed discreetly out of sight, in case any participant became emotional.
- A notepad and pens, used by the researcher to keep field-notes.
- Copies of the informed consent form and information document.
- The following notice was placed on the closed door:

Please do not disturb, interview in progress.

The focus group:

- Participants were greeted and invited into the designated group therapy room at The Second Clinic.
- The focus group process was explained, including the reasons for using the digital recorder and writing field notes (Henning *et al.* 2004:75).

- The process of informed consent between researcher and participants was completed, and the participants reminded that information gained during the interview would be treated confidentially (cf. 3.7.5).
- Up to now, the researcher remains aware of the participants' possible need to be reassured about this seemingly abnormal situation of engaging in an interview with a stranger. It is important to establish a level of trust, in order to allow the participants to participate successfully and with ease.
- The researcher initiated the focus group by asking the most prominent question:

What do I need to know about your culture?

- The discussion was then further facilitated by the researcher applying many interviewing skills, including those proposed by Rubin and Rubin (2005:352) – Table 3.1 (cf. 3.3.4.1)
- The focus group continued for 1 hour and 43 minutes, which included a short break.
- During and after the interview, the researcher took notes, including descriptive and reflective notes.
- Upon completion of the focus group, the researcher invited the participants to ask any questions they wanted to; then thanked them for participation and greeted them.

3.4.4 Data management

Data was managed in a similar way than with the individual interviews (cf. 3.3.5): digital recordings were made, which were then transcribed by the researcher. Hard copies were stored, together with field notes made by the researcher during the focus group.

3.4.5 Data analysis and interpretation

The *interpretive thematic analysis approach* (Carpenter & Suto 2008:48) has been used in the analysis of data – the same approach that was used for the analysis of data from the individual interviews (cf. 3.3.6). The same co-coders involved in the coding of the first set of data, were employed for the coding of the data collected during the focus group, adding to the quality and rigor of findings.

3.5 QUALITY AND RIGOR OF DATA

In this section, the strategies employed to ensure maximum quality and rigor of data, are discussed. Please take note that the section covers all data included in the study – during individual interviews and the focus group.

The outcomes of this study are supposed to inform culturally relevant practice for the patient population at both Clinics. In order to ensure the maximum quality of data, several strategies were employed, i.e. triangulation, and adhering to the criteria of credibility, dependability, confirmability and transferability.

Triangulation refers to the use of a combination of methods, data sources and theoretical perspectives in the same study in an effort to ensure trustworthiness of data (Carpenter & Suto 2008:152; Flick 2002:226; Polgar & Thomas 2008:137). Flick (2002:226), and Lewis and Ritchie (2003:276) describe the four kinds of triangulation as initially identified by Denzin in 1978 and 1989, and again in 2005. These include data triangulation – using different sets of data; method triangulation – using more than one method of data collection; theory triangulation – checking data with literature and theories; and investigator triangulation – involving more than one researcher in the analysis of data. In the present study, a case study which is multi-method in nature;

data was checked with literature and co-coders were employed. Method, theory and investigator triangulation were thus conducted.

The criteria of credibility, dependability, confirmability and transferability have been used in striving to optimal quality of data. These have initially been proposed by Lincoln and Guba in 1985, and are still widely used to evaluate the quality and rigor of qualitative data (Carpenter & Suto 2008:148; Creswell 2009:190; Flick 2002:228; Polit & Beck 2006:332-339).

Table 3.3 - Trustworthiness of qualitative data

CRITERION	QUESTION TO BE ASKED BY THE RESEARCHER? (Carpenter & Suto 2008:149-150)	STRATEGIES TO BE EMPLOYED IN ORDER TO ENSURE RIGOR AND QUALITY
Credibility	Can data be accepted as true and reliable?	• **Prolonged engagement with data**. The researcher conducted all individual interviews and the focus group interview. She spent much time with data, including conducting all interviews, typing the transcriptions and analyzing data according to the chosen process. • **Researcher credibility** was of utmost importance. Even though the researcher is inexperienced; study leaders guided this study. The study was only conducted upon approval by the following committees: Expert committee of Dept. of OT, UFS. Evaluation committee of the School of Allied Health Sciences, UFS. Ethics Committee of the Faculty of Health Sciences, UFS. The researcher had clinical experience in presenting group therapy to the population; for 22 months at The

		Clinic, and 19 months at The Second Clinic. Furthermore, there were no hypothesis to prove, and the researcher was only working towards a description of the context of a population. Personal biases were thus limited, even though the influence of biases and ideologies were still acknowledged and the researcher had to be aware of this throughout the study and when reporting findings. • **Theory triangulation** was used to 'verify' data (Creswell 2009:191; Flick 2002:226; Lewis &Ritchie 2003:276). • **Member checking** (Carpenter & Suto 2008:153; Creswell 2009:193)/ was not done, due to the logistical problems associated with tracking the participants and requesting further engagement in the study.
Dependability	Can the decisions made with regards to methodology be	The study was audited by study leaders, who were supervising the researcher (Carpenter & Suto 2008:152).

	defended? Does the methodology fit the findings?	The researcher got to know the population and the study quite well; but would not benefit from any findings of the study and could therefore conduct an independent audit (Creswell 2009:177). The research proposal was submitted for approval by the following committees: ○ Expert committee of Dept. of OT, UFS. ○ Evaluation committee of the School of Allied Health Sciences, UFS. ○ Ethics Committee of the Faculty of Health Sciences, UFS. The case study allows and requires a comprehensive description of the case, which would be evident also in the discussion of findings of the present study (Lewis 2003:52&76).
Confirmability	Is data objective and neutral? Did own perspectives and	Once again auditing played an important role (Carpenter & Suto 2008:152). The researcher remained accountable to her study leaders as auditors. Data, field

	biases influence the findings?	notes and any other information was made available for inquiry by said persons. Two co-coders were consulted in this regard, as discussed in 3.3.6.
Transferability or applicability	Can data be applied to similar settings or contexts?	The researcher aimed for detailed, or 'thick' description of data (Carpenter & Suto 2008:157; Creswell 2009:191) compiled in the interviews, in order to allow other therapists to apply the guidelines in settings similar to The Clinics. Theory triangulation also played an important role in ensuring transferability (Flick 2002:226).

3.6 ERRORS IN DATA COLLECTION

The methodological and measurement errors for this study, are described in Table 3.4 below.

Table 3.4 - Methodological and measurement errors

POSSIBLE ERROR	STEPS THAT WERE TAKEN TO LIMIT THE EFFECT OF MENTIONED ERROR
In the interview, leading questions may have been asked, leaving participants to answer as they think is expected of them, rather than providing authentic answers.	– The pilot study, and auditing by study leaders, have been employed in order to optimize interviewing skills.
The participants did not know the researcher.	– This could have served as a disadvantage, in that participants might not have felt comfortable sharing personal information with the researcher. – The researcher aimed to minimize this effect by reassuring the participant about confidentiality, and her genuine interest in learning about the participant's life. – It was interesting to note that several of the participants spontaneously expressed their gratitude at being able to talk to somebody, albeit a stranger. The researcher took this as some proof that being a stranger to the participants, did not necessarily affect the findings negatively. Once again, guidelines from Rubin and Rubin (1995) have been followed to encourage spontaneous participation.

The participants were not English first language speakers, and may not have been able to express themselves sufficiently in English.	– The researcher was aware of this challenge, and made sure to give participants enough time to express themselves. If it seemed a participant was not able to participate sufficiently in the interview, data would have been deleted due to lack of language proficiency. Another participant would then be invited to participate in an interview. Please note that all participants worked in the public or private sector, and reported they were speaking English on a daily basis. The fact that interviews were conducted in English, the second language of both researcher and participant, could be problematic. However, the researcher did not wish to employ the services of a translator or mother-tongue interviewers, since both the researcher and participants all understand English well enough to engage in conversation. The researcher acknowledged that some information could get lost by making use of English instead of mother-tongue, but the fear of getting 'lost in translation' prevented her from employing translation services

	or another interviewer.
The researcher, acting as a tool of measurement, had her biases, ideologies and expectations for the study. This may have influenced her interpretation and analysis of data (Creswell 2009:177).	– The study leaders and two co-coders were part of the research process, and held the researcher accountable for findings of authentic quality. – The researcher, as far as possible, identified her own biases and expectations for the study, and strove to limit the impact thereof on the final findings.

Please refer to Table 3.3 (Trustworthiness of qualitative data) in 3.5 for pointers on data quality control which were also taken into account throughout this study.

3.7 ETHICAL CONSIDERATIONS

Ethical considerations are defined by Strydom (2005a:57) as:

> *a set of moral principles…which offers rules and behavioural expectations about the most correct conduct towards experimental participants.*

Ethical guidelines according to the classification by Strydom (2005a:57) were followed during the planning and conducting of the study in order to ensure responsible conduct towards all participants involved in the study. Guidelines provided by Carpenter and Suto (2008:50), Creswell (2009:87-93) and Lewis (2003:66-71) are similar to Strydom's.

3.7.1 Avoidance of harm

With physical harm not being a factor in this study, the measuring instrument was scrutinized to ensure that emotional harm (i.e. discomfort or other unpleasant emotions) would not be evoked by the questions. Would any participant become upset during an interview, a debriefing session would have been arranged with a member of staff at The Clinic.

3.7.2 Debriefing of participants

Debriefing were not considered necessary in this study, since participation was limited to a single interview. If any participant became emotionally upset during or immediately following an interview, debriefing would be arranged by the researcher.

3.7.3 Informed consent

Participants were issued with an information leaflet on the study on the day of the interview, explaining the purpose of the study; procedures; confidentiality and implications of participation (Creswell 2009:89). This happened prior to participation, to allow voluntary participation or withdrawal. Informed consent was obtained from all participants, and this included the following steps:

An informed consent form – available in English and Sesotho, was signed prior to participation in any interview (Appendixes C & D). Participants received verbal reiteration that no remuneration was offered, that participation was free and voluntary and that any participant may withdraw during any stage of the study. They were also informed about the recording of interviews; that confidentiality would be maintained and that all questionnaires and interview sheets would only contain participant numbers and not names.

Consent was obtained from all the interested parties at Both Clinics, including the occupational therapy practices and the treating psychiatrists. They were provided with a complete information piece on the study (Appendix E & F).

3.7.4 Deception of participants

At no point during the study, any participant was deceived about the purpose of the study or the experiences they would undergo (i.e. the interview and focus group session).

3.7.5 Violation of privacy: anonymity and confidentiality

Privacy and anonymity could not be guaranteed, due to the nature of the methodology of this study, with participants engaging in interviews. However, privacy of participants was protected by not disclosing findings on specific participants, or disclosing information in such a manner that any participant was identifiable from an anonymous description.

Confidentiality was guaranteed; with the researcher not carelessly disclosing personal information gathered during any interview. Data gathered during the interviews was essential to reach the aim of the study, and was therefore interpreted, reported and/or discussed in this dissertation. However, the privacy of participants was protected as described in the previous paragraph. Questionnaires and interview notes were numbered and each participant's name was replaced by a number, to further confidentiality. (Names were not written on any documentation containing data).

Should a participant disclose information relating to harming himself or committing suicide, the researcher would have been obligated to discuss this matter with the

participant with a view on disclosing the matter to the attending doctor or sister in charge.

3.7.6 Actions and competence of researchers

The research proposal was presented to the following committees for approval prior to conduction of the study:

Expert committee of Dept. of OT, UFS.

Evaluation committee of the School of Allied Health Sciences, UFS.

Ethics Committee of the Faculty of Health Sciences, UFS.

Strydom (2005a:64) points out the importance of researcher competence especially when conducting research across cultural boundaries. The nature of the study was inquiring and interpretive, which may have left the researcher at risk of making assumptions or incorrect interpretations. The researcher strove to optimal competence by discussing this study with experts in the field of occupational therapy in mental health, as well as by not making judgements or assumptions about cultural values. Reporting information correctly was also deemed as the ethical responsibility of the researcher (Creswell 2009:92).

3.7.7 Cooperation with contributors

No sponsors were involved, apart from a bursary from the School of Allied Health Sciences; which did not have any influence on findings. Staff at The Clinics were regarded as great contributors and acknowledged accordingly.

3.7.8 Release or publication of the findings

Participants were informed of the researcher's intention to publish the findings. The actual names of The Clinics were not and shall not be mentioned in any publications, in

order to protect these clinics from unfair and uninformed scrutiny. Findings will be released to both Clinics, specifically to the relevant occupational therapy practices.

3.7.9 Other aspects that were considered in the best interest of participants and professional colleagues:

- Psychiatrists were informed of their patients' participation in the study.
- All interviews were conducted in English, since the participants' were all attending the English group program at The Clinics.
- Participants were at no point during the study withheld from the standard program or appointments with other clinicians.
- The Clinics were not put in a bad light, at any point during the study or after, by implying anything about the quality of the current group therapy programs.
- Taking into account the above mentioned statement, the researcher did however remain honest with professional colleagues or patients at The Clinics about the ultimate purpose of the study: to make recommendations with regards to culturally relevant OT practice at these clinics.
- Assistant researchers i.e. study leaders and co-coders were expected to adhere to the same ethical guidelines as described in this proposal.
- Apart from the ethical aspects to be considered during execution of this study, the researcher believed it was her ethical responsibility to conduct this study (Watson 2006:158), in order to ensure 'best practice' in the OT program at The Clinic (Creswell 2009:88). Best practice is also inextricably linked to ethical practice, according to Braveman (2006:357).

If the expected outcome of this study is reached (i.e. guidelines for culturally relevant practice), it may be valuable in ensuring that the OT services offered at The Clinics, are providing in the needs of the population.

3.8 CONCLUSION

This chapter described the research methodology pertaining to this study: a qualitative design, with an interpretive approach. The collective case study was utilized as the strategy of inquiry. The sample was taken from a population of Sesotho speaking adults, attending the English inpatient group therapy programs at The Clinic and The Second Clinic. Twelve (12) individual interviews were conducted at The Clinic, following an interview schedule based on the Kawa model. These were followed by a focus group session at The Second Clinic, with another eight participants. Interviews were transcribed, and interpretive thematic analysis was done by the researcher and two co-coders. Measures to limit errors in data collection are discussed, as well as strategies to ensure quality and rigor of data. The ethical considerations that were taken into account during the planning and conduction of the study, are described.

Chapter 4 will present the findings, with discussion and interpretation according to relevant literature.

Chapter 4

Presentation and Interpretation of Findings

The research methodology for this study was discussed in the previous chapter. This chapter seeks to present the findings that were collected in exploring the research question for this study:

> *What are the occupations and socio-cultural context of the Sesotho speaking adults admitted with mental health problems?*

Firstly, the participants to the study are introduced to the reader. Thereafter findings, collected by means of individual interviews and a focus group interview, are presented and discussed within the context of relevant literature.

4.1 INTRODUCTION OF PARTICIPANTS

Two samples have been selected for participation in this study. The first sample participated in individual interviews with the researcher at The Clinic during which the Kawa Model was used for inquiry, and the participants were given the opportunity to describe their 'lives as rivers'. The second sample participated in the focus group interview at The Second Clinic. Pseudonyms are used throughout the dissertation, including appendixes, to protect confidentiality.

4.1.1 Participants in individual interviews

Twelve participants, six male and six female, between 27 and 49 years of age, agreed to participate in individual interviews. They all reported their ethnicity to be

'black, Sesotho', with Sesotho being their home language. With regards to education, the highest level reported was a B.Sc. Degree, with Grade Eight the lowest level of education. All of the participants were permanently employed in the public and private sectors, with jobs including the following: South African Police Services (SAPS), Correctional Services Officers, Financial Clerks, an Environmental Officer, Traffic Officer and Performance Manager. Of the 12 participants, six reported to be working shifts, instead of 'normal' eight-to-five working days. They reported their main needs during their stay at The Clinic to be: medication, counselling (individual or couples counselling), group therapy, rest and support from peers and professionals.

The size of the sample was sufficient, since data collection proceeded until a point of saturation (no new significant information was obtained). The selection criteria (cf. 3.3.2.1) was strictly followed and is reflected in the similar biographic information of the sample as introduced in Table 4.1 below.

The participants are introduced by means of a short synopsis of biographical information, with some details from field notes made by the researcher during or after interviews.

Table 4.1 - Case profiles of individual participants

Participant	Case profile: an introduction to the participant (Pseudonyms are used to protect confidentiality).
Participant 1: Nthabiseng	**Nthabiseng** is a 32 year old female, working as an environmental officer. She reported her main reason for admission as having 'problems' at work, with depression as diagnosis on axis 1. This was her first admission to a Mental Health Care Facility (MHCF). Even though very soft-spoken, she was really involved in the interview-process and seemed to grasp the concept of the Kawa Model really well. She told me that it was a relief to talk to someone about 'everything'.
Participant 2: Daisy	**Daisy**, 28 years old and female, works as a security officer at a Correctional Facility, and reported marital problems and suffering abuse to be her main reasons for this first admission. She had quite an attack of hay fever and sneezing during the interview, but still participated. Akin to Nthabiseng, she expressed her relief to talk to me about 'everything'.
Participant 3: Tulane	**Tulane**, a 42 year old mother and financial clerk, was admitted to The Clinic after her son went missing for five days. This is her second admission to a MHCF, as she was previously admitted for depression. Tulane has been HIV positive for several years now, and often mentions the impact thereof on her life, during the interview. She portrayed great excitement about participating in the interview, since she has family members who are also involved in 'research'.

Participant 4: Thabo	**Thabo** is a 35 year old male, who reported his main reasons for admission as great frustration in going through a separation from his wife; and not being allowed to see his children. He reported this admission with depression as his first. In the interview, he initially seemed to grasp the Kawa Model really well, and then proceeded to tell his entire life story without prompting by the researcher, and without relating his narrative to the metaphor of the river at all. Even so, he still provided valuable information on his occupations. He works as a manager, specifically with performance management.
Participant 5: Mary	**Mary,** a 49 year old female, works as an administration clerk at a school. She reported her greatest stressor and cause of this first admission with depression, as marital problems due to a lack of communication with her husband. She did not seem to grasp the idea of seeing her 'life as a river' well, although she had a good understanding of her own life and problems. When she did not understand, she was quick to ask.
Participant 6: Tshiamo	**Tshiamo** is a 29 year old male traffic officer. He stated his work circumstances and relationship with his girlfriend as main contributors for admission; his first to a MHCF. He did not know his diagnosis for this admission. He presented very agitated when talking about his girlfriend, even so, he participated actively and seemed passionate when talking about topics other than his girlfriend.

Participant 7: Simon	**Simon** is a 43 year old male, working as a data capturer at the SAPS. He reported his main reason for admission the fact that his wife filed for divorce without him carrying any knowledge of her plans to do so. He highlighted depression and alcohol abuse as his main diagnoses for his admission to The Clinic. I found this interview most difficult: Simon spoke very softly, and apart from struggling to hear what he was saying; it was also difficult to follow his train of thought.
Participant 8: Masabatha	**Masabatha**, a 27 year old female, works as a security officer at a Correctional Facility. She works night shifts only. In her free time, she works as a volunteer for 'Lovelife'[3]. She lives with diabetes, a great stressor in her life. She was the first participant to describe depression as her main reason for admission and her diagnosis. She seemed to enjoy the interview very much, and participated with great enthusiasm.
Participant 9: Mphohadi	**Mphohadi** is 36 years old, a male police official in the 'Crime Prevention Unit' of SAPS. He reported as main reasons for admission, his recent change in behaviour; aggression and alcohol abuse. He stated his diagnosis for this 2nd or 3rd admission to a MHCF, as depression. He participated actively in the interview.

[3]**LoveLife (2011:online)** is a South African HIV prevention initiative for young people; committed to reducing the prevalence of HIV/Aids through youth development. (www.lovelife.org.za/)

Participant 10: Jakes	**Jakes**, a 30 year old male, works as a constable in the SAPS. He explained that depression was the reason for this 2nd admission to a MHCF. He previously worked as a lay counsellor for 'Lifeline'[4], and relayed many of his anecdotes and comments back to this experience. He seemed to enjoy the interview very much.
Participant 11: Morena	**Morena** is 27 years old, male and working as a police official in the 'Social Crime Prevention' unit. He is also the chairperson of the Community Police Form. At the time of the interview, he was going through a break-up with his girlfriend, with whom he lived. He described this as his main reason for this 1st admission, and could not report a diagnosis. He participated well and answered questions very thoroughly.
Participant 12: Bayo	**Bayo** is a 30 year old female security officer, living with Diabetes. She reported turning temporarily blind prior to being admitted to The Clinic, and ascribed this phenomenon to stress. She stated 'stress' as her main reason for admission, as well as her diagnosis for this 2nd admission. She was very animated during the whole of the interview, which she later described as very enjoyable.

4.1.2 Participants in the focus group interview

Eight (8) participants, three male and five female, agreed to participate in the focus group interview at The Second Clinic; and were included according to the selection criteria in 3.3.2.1.

[4]**Lifeline (2011:online)** is a non profit organisation that provides a 24-hour crisis intervention call-centre service; an "Emotional First Aid station". (http://www.lifeline.org.za/)

All members were of working age, between 18 and 60 years old. All reported to be living in Sesotho communities and speaking Sesotho as their first language and/or mother tongue.

Puleng is completing her training as a nurse or health-care assistant. *Olivia* works in a well-known bank in Bloemfontein. *Moreng* works as an administration clerk at a Primary Health Care Clinic in a small town in the Southern Free State. *Bokang* is 18 years old and still attending school. *Lerato*, *Tsego and William* are teachers; and *Jennifer* is a senior administration officer at the Department of Agriculture.

A seating plan of the focus group session is provided in Figure 4.1 below, with the pseudonyms and sex of participants indicated.

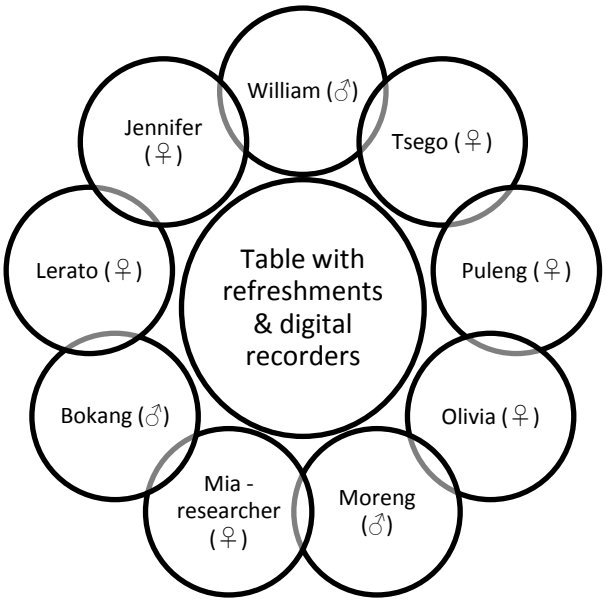


Figure 4.1 - Seating plan for the focus group session

With regards to participation in the interview, Tsego lead the discussion, with Jennifer and Lerato also taking more opportunities to speak than the other

members. Olivia, Moreng, Puleng and William provided minimal input, with Bokang only speaking when directly invited by the researcher.

4.1.3 Discussion of both samples

Participants were recruited during a process of purposive sampling, which allowed me to invite people who would contribute to an understanding of the Sesotho speaking adult with mental health problems, according to selection criteria. The selection criteria (cf. 3.3.2.1) were strictly followed and resulted in two samples as described above in 4.1.1 and 4.1.2.

In summary, it can be said that the 20 participants are representative of the population of Sesotho speaking adults attending the English group therapy programs at The Clinics. Their basic biographic information, such as age, sex and employment status are similar to that of the larger population. Even more importantly, their diagnosis and main complaints about stressors and mental health issues, were also comparable to the clinical experience I gained in working with the population before.

4.2 PRESENTATION OF DATA

In the following paragraphs, findings from the individual interviews and focus group are presented, integrated and discussed. Verbatim quotes and 'thick description' (Creswell 2009:191) are utilized to enrich the presentation of data, by providing the reader with a literary picture of the participants and the contexts in which they live (Ponteretto 2006:541). The interpretive nature of the discussion is furthered by applying theoretic triangulation (cf. 3.3.6), where findings are compared with existing theories and literature (Creswell 2009:189; Flick 2002:226).

Table 4.2 below offers a schematic presentation of the themes, categories and sub-categories, and is provided to orientate the reader with regards to the outline of data.

With socio-cultural context being a salient theme in this study, it was deemed necessary to discuss it throughout and simultaneous with all the other themes. In other words, the data on the socio-cultural context of the participants, have been discussed throughout the themes of occupations, values and emotions; in order to provide it with as large a lay-out as possible. Any data on socio-cultural context which could not be presented and discussed with other themes, will be discussed in 4.2.4.

Table 4.2, containing the themes deducted during the process of content analysis, follows on the next page.

Table 4.2 - Themes deducted during the process of content analysis. (Categories within each theme are presented later as indicated by the numbers of subtitles in this chapter).

RESEARCH QUESTION	THEMES	CATEGORIES	SUB-CATEGORIES
What are the occupations andsocio-cultural context of the Sesotho speaking adult at both The Clinic and The Second Clinic?	4.2.1 Occupations	4.2.1.1 Work	Work as a source of stress and/or support
			Stressors at work: interpersonal conflict and complaints of unfair treatment
		4.2.1.2 Sleep	Poor sleep hygiene
			The use of medication to induce sleep
		4.2.1.3 Leisure	Perception of leisure
		4.2.1.4 Personal management	Poor skill in personal financial management
		4.2.1.5 Social participation	Family: A great source of support vs. A great source of stress & responsibility
			Psychosocial life skills
			Marital dysfunction
	4.2.2 Emotions	- Feeling overwhelmed - Experience of emotional relief after talking	
	4.2.3 Values	- The importance of a positive mindset - Involvement in family - Involvement in community structures & activities - Spirituality and religion	

RESEARCH QUESTION	THEMES	CATEGORIES	SUB-CATEGORIES
What are the occupations and socio-cultural context of the Sesotho speaking adult at both The Clinic and The Second Clinic?	4.2.4 Socio-cultural context	4.2.4.1 The nature of participants' culture	4.2.4.1.1 Subcultures exist within the Sesotho culture - "we are Basotho's but we are different". 4.2.4.1.2 Our culture is changing – "we do not know what to do"
		4.2.4.2 Being Sesotho are associated with certain cultural beliefs or 'superstitions'.	
		4.2.4.3 Culture influences important social structures.	4.2.4.3.1 Females are regarded as subordinate[5] to men. 4.2.4.3.2 The elders dictate and support – on their own terms
		4.2.4.4 Stigma exists regarding mental health conditions	

4.2.1 Occupations

In the process of data collection (specifically the individual interviews), much information was obtained by allowing participants to explain their 'lives as rivers', according to the Kawa Model. It was interesting to note that most participants leaned toward a discussion of their occupations, even though the Kawa Model does not specifically prompt participants in the direction of occupations. However, I was allowed to ask probing questions during the interview (cf. Appendix B) – provided it was to require the participant to elaborate on answers linking to occupations and

[5]Subordinate: of inferior importance.

socio-cultural context (i.e. answers relating to work, sleep, social participation, leisure and personal management).

Occupations have been classified in the concept clarification as work, sleep, leisure, personal management and social participation; and this classification is also used in the writing up of findings. Chapter 2 (cf. 2.2) affirmed the positive link between health and balanced participation in occupations (Blair *et al.* 2008:26; Chapparo & Ranka 2005:57; Creek 2008:76; Molineux 2004:2). It is therefore in line with the research question to further this discussion on findings relating to the occupations of the participants with mental health problems.

In this presentation of the findings on the occupations of the participants, the reader will note the influence of socio-cultural context on the participants' choice and performance of occupations (Adams 2009:10). These socio-cultural influences are discussed throughout, and then finally in 4.2.4.

Occupations are presented as separate categories; as work, sleep, leisure, personal management and social participation. Each category (i.e. work) is presented with it's own scheme of sub-categories. Verbatim quotes are presented in the discussion of each occupation, to illustrate why the category was chosen as a category, and to prove that the principle of saturation was followed.

4.2.1.1 Work

Work was identified as one of the major categories in the theme of occupations. Participants' responses included many comments about the positive and negative aspects of work as one of their occupations. These responses are reflected in the sub-categories of work as a source of stress and/or support; and stressors at work.

THEME	CATEGORY	SUB-CATEGORIES
4.2.1 Occupations	4.2.1.1 Work	4.2.1.1.1 Work as a source of stress and/or support
		4.2.1.1.2 Stressors at work: interpersonal conflict and complaints of unfair treatment

4.2.1.1.1 Work as source of stress and/or support

Many participants identified their jobs ('work') as rocks in their rivers, impeding the flow of life by adding stress to daily living. Tsego (a teacher), Mphohadi (a police officer) and Tshiamo (a traffic officer) highlighted work as a source of at least some level of stress, although they were initially vague about specific work stressors.

> ***Tsego:*** *No, even me, that stress is coming again, over from the work now.*

> ***Mphohadi:*** *But at work, I don't know…it's a problem. It's frustrating.*

> ***Tshiamo:*** *It's (work) a problem that upsets the water…*

Work stress is known to have a negative influence on a person's wellbeing (Van der Colff & Rothmann 2009:1); a fact that supports the participants' comments above.

Work stress stem from physical and/or psychological job demands (Pienaar & Rothmann 2006:72); and specific stressors may include work load, insufficient support from colleagues, role conflict and a lack of personal feedback (Rothmann, Jackson & Kruger 2003:58). Pienaar and Rothmann (2006:72) point out that individuals may experience work stressors differently, according to their unique personality traits. (The study of personality traits is beyond the scope of this study, but I also acknowledge that it may be playing a role in the reports of work stress).

Work stress has been proven to lead to exhaustion, and even burnout; which may include, apart from exhaustion, cynicism and a sense of poor professional efficacy (Rothmann *et al.* 2003:53). Work stress is associated with many stress-related conditions, including mental disorders, hypertension, upper respiratory tract infections, stomach ulcers, asthma and migraine, to name a few (Peltzer, Shisana, Zuma, Van Wyk & Zungu-Dirwayi 2009:247; Pienaar & Rothmann 2006:72).

It is interesting to note that the present study sample includes four police officers and two teachers; and that they were quite verbal about work stress. In two studies on stress levels among South African teachers (Peltzer *et al. 2009)* and South African police officers (Pienaar & Rothmann 2006:72), most of the stress related conditions mentioned above, were prevalent and directly linked to job stress experienced by the teachers and police officers.

In spite of this negative introduction to the work life of the Sesotho speaking adult with mental health problems, it seems a duality of perceptions exist about work. Work is regarded by some participants as a source of both stress and support. The following astute comment by Nthabiseng, an environmental officer, was the first pointer towards this duality:

> ***Nthabiseng:*** *We talk as patients, and I've realized that a few have work problems like me...(...) I feel that my water is not flowing...because – as much as the job is a support system it is also the biggest rock.*

On the more positive side of this dyad of perceptions, Jakes (a SAPS officer), Tulane (a financial clerk) and Mary (an administration clerk) provided me with powerful quotes on their experience of their working places being sources of support.

> ***Jakes:*** *My work, my boss… they are my pillars.*

> ***Tulane:*** *So I don't have a problem at work, it's a support.*

> ***Mary:*** *(My job is)…Very nice! Because we are together, we are enjoying together… there is no conflict.*

These positive experiences of the workplace, are in line with the benefits of work for the individual, as identified by Creek (2008:40). These benefits range from offering roles in society and a sense of purpose and satisfaction; to improving self-esteem. Woods and West (2010:346) agree with Creek on the social and emotional benefits of work, by stating: "Positive relationships and a sense of community are the product and cause of positive emotions". Furthermore, Carmeli (2009:45) points out a positive link between positive work relationships; feelings of vitality (referring to a person being energetic and fully functioning) and enhanced job performance.

In conclusion about this duality of work as a source of stress and/or support: Bakker and Schaufeli (2008:150), report that job demands should not lead to burnout, if sufficient job resources (including social support) are available. It seems that job resources can protect the employee from adverse effects of job demands; and even increase the employees' satisfaction, commitment and ultimately their engagement in work (Bakker & Schaufeli 2008:151-152).

To bring these viewpoints back to the study population: many participants are reporting work stress, even though they do not report specific stressors other than interpersonal conflict and the perception of unfair treatment (cf. 4.2.1.1.2). However, some regard the work place as a great source of support; which is positive, especially when taking into account Carmeli's notion (2009:45) that positive relationships could increase a sense of vitality.

4.2.1.1.2 Stressors at work: interpersonal conflict and complaints of unfair treatment

Following the previous sub-category which identified work as a source of stress, the two specific work stressors mentioned by participants, are now discussed.

When work stressors were specifically identified, it often had to do with interpersonal relationships and conflict at work.

> ***Daisy:*** *It's colleagues (….) – they try to get into my personal life, also talking about me and my marriage and how it is…so I don't even like my work at the moment.*

> ***Tshiamo:*** *There are those colleagues who are sidelining with the management…some of them you'll be with them, someone will come to you and behave as if he or she's going to be sympathetic to you, when he is sucking information for management… and then as a result, the management… they are going to deal with you. There are people you can't trust… most of the time…*

As mentioned by Daisy and Tshiamo, relationships with colleagues are often strained. In a review of qualitative studies on occupational stress, Mazzola, Schonfeld and Spector (2011:93&97) reported interpersonal conflict at work as the most prevalent stressor[6], across all nations and regardless of vocation. It is therefore not anomalous for the sample in the present study to experience interpersonal conflict at work. To bring this notion of work stress closer to the participants in the study, it can be linked with mental health. Oksanen, Kouvonen, Vahter, Virtanen, Kivimäki (2010:684) report that an employee's mental health, can be influenced by the quality of relationships with people in positions higher than the employee, as well as colleagues on the same level. Even if a persons' mental health is not directly influenced by interpersonal conflict at work, he may portray counterproductive work behaviour, whilst experiencing decreased job satisfaction (Ilies, Johnson, Judge, Keeney 2011:45) and negatively affected affect (Ilies *et al.* 2011:46).

With interpersonal conflict at work being part of 'just another day on the job', positive ways of coping with it, have to be explored. Ilies *et al.* (2011:57) found that social support, in the event of interpersonal conflict, may decrease the negative

[6]Stressors are regarded as conditions or situations that elicit an emotional response such as anger or anxiety in a person (Mazzola, Schonfeld and Spector 2011:93).

effects thereof. This 'social support' would include actions which may be perceived by the person on the receiving end, as the supporter being helpful and concerned. Based on their finding that social support can mediate the effects of conflict, Ilies *et al.* (2011:60) recommend employees to actively seek social support when experiencing conflict at work.

The second source of work stress that was specifically mentioned by participants, was the perception of unfair treatment at work. Several examples follow:

> ***Nthabiseng:*** *Unfair treatment…by people above me.*

> ***Mia:*** *So how will we describe this situation with your commander?*
>
> ***Mphohadi:*** *It is unfair.*

> ***Morena:*** *And now he wants me to do both jobs. And now – I can do what – he will strike me down... I don't understand this.*

> ***Tshiamo:*** *(My job) It's a problem that upsets the water…. it's because the management where I'm working….ah….they tend to be nice people, but now they are autocratic leaders, so they want things to be done on their way. So they can't listen to anyone. Even if you like...they don't have any position in management…they can't even listen to*

> *you…whether it's a lawful instruction or an unlawful instruction(…)*

Meier, Semmer and Hupfeld (2009:643) acknowledge unfair treatment as a work stressor, and then provide a candid background to the perception of unfair treatment at work (Meier *et al.* 2009:644):

> *People care about fairness because fair behavior symbolizes that they are valued and respected members of a group, providing them with a high level of perceived inclusion in the group. To summarize, unfair treatment may be generally perceived as a threat to social inclusion and likely to affect people's well-being.*

Whatever the background to a person's perception of unfair treatment, it is necessary to understand that his well-being and setting of goals may be negatively influenced (Oyserman, Uskul, Yoder, Nesse & Williams 2006:505). The person feeling unfairly treated, may even decide to leave the job, or "take a principled stand", which may in turn cause significant stress (Oyserman *et al.*2006:510).

It is interesting to note that two of the complaints about unfair treatment, came from police officers (Mphohadi and Morena), and the third from a traffic officer (Tshiamo). Pienaar and Rothmann (2066:73) in a study of police officers (N = 2145), found the foremost source of stress, organizational aspects including a "lack of confidence in management".

As can be seen in several of the verbatim quotes used throughout 4.2.1.1 so far, participants associate work stress with unpleasant emotions. Tshiamo provided a

clear explanation of the effect of work stress on his emotions and consequently his mental health:

> ***Tshiamo:*** *I mean, you are nervous sometimes, you are depressed… it's like, when you wake up in the morning, you decide, maybe I should take some leave and stay for a while. Or should I take a cross-transfer to the SAPS...?*

Tshiamo's link between the effect of work stress on his mental health, is confirmed by Stoetzer, Ahlberg, Johansson, Bergman, Hallsten, Forsell and Lundberg (2009:144). Their study of a sample of 4040 employees, indicated interpersonal conflict as a determinant of depression. De Vogli (2010:684) agrees on the detrimental effect of poor interpersonal relationships at work, on mental health. Ilies *et al.* (2011:45), Meier *et al.* (2009:644) and Oksanen *et al.*(2010:684) all agree that work stress has a negative influence on a person's wellbeing and mental health; which could include depression.

In conclusion about work as a category of occupations: as seen in 4.2.1.1.1, good relationships at work are expected to have a positive effect on the participants. This positive effect is expected to be seen in their overall improved wellbeing and job performance (Carmeli 2009:45-71). Conversely, in 4.2.1.1.2, poor interpersonal relationships are expected to cause negative affect and even depression, as identified by participants and confirmed by literature (De Vogli 2010:684; Stoetzer *et al.* 2009:144). Keeping in mind this adverse effect of workplace conflict on mental health, it is therefore not surprising then that many participants in the present study (of whom most has been admitted with depression as main diagnosis) reported much interpersonal conflict at work. With work being only one of the main five occupations in this study, it is important to consider the probable effect of work stress on a person's participation in other occupations. Work stress may lead to a

depressed mood, which in turn affects motivation to participate in activities which may provide a person with satisfaction, pleasure and rest. Using the terms of the Kawa Model: work may prove to be such a large rock in a person's river of life, that the flow of water/life is totally restricted.

4.2.1.2 Sleep

Sleep emerged as a major rock in the rivers of the participants, and was labelled as one of the categories relating to occupations. Participants' reports of their sleeping problems related to two sub-categories, i.e. poor sleep hygiene[7], and the use of medication to induce sleep.

THEME	CATEGORY	SUB-CATEGORIES
4.2.1 Occupations	4.2.1.2 Sleep	4.2.1.2.1 Poor sleep hygiene
		4.2.1.2.2 The use of medication to induce sleep

4.2.1.2.1 Poor sleep hygiene

Sleep hygiene refers to lifestyle habits followed to enable good sleeping, or prevent sleeping problems (Barlow & Durand 2009:300). These habits include:

- A regular bedtime routine
- Avoidance of food and drink containing stimulants (i.e. caffeine) six hours prior to bedtime.
- Avoidance of exercise or participation in vigorous activities in the hours before bedtime.

[7] Sleep hygiene refers to lifestyle changes made in order to help avoid problems such as insomnia (Barlow & Durand 2009:299).

- Limited use of alcohol and tobacco.
- A balanced diet; and drinking milk before bedtime.
- Going to bed when sleepy and getting up when unable to sleep.
- Daily exercise, although not in the hours before bedtime.
- Environmental aspects: reducing noise, light and extreme temperatures in the bedroom.

Now that a background on sleep hygiene has been established, the data gathered on sleep as an occupation for the present population, is presented. A lack of sleep seemed to be a prevalent problem amongst participants. During the individual interviews, Mary, Tshiamo and Masabatha specifically mentioned experiencing problems with sleep.

> ***Tshiamo:*** *The thing is I wake very early in the morning. I can go to bed any time…it doesn't matter, but I will still wake up early.*

> ***Mary:*** *I can't sleep…I can't sleep.*

Moreng, in the focus group, mentioned a lack of sleep prior to admission, and was supported by several members of the focus group:

> ***Moreng:*** *No we don't sleep enough at home. Four hours...five hours.*

In a study of Sesotho speaking patients with mood and anxiety disorders, more than 50% of Sesotho-speaking suffered with insomnia [8] (Mosotho, Louw, Calitz & Esterhuyse 2008b:176). Fink (2009:258) confirmed insomnia as a sign of psychological stress, specifically following stressful situations at work, interpersonal or financial in nature (Fink 2009:259). From my own experience in working with Sesotho speaking adults with mental health problems, most of them seem to crave sleep during their first days of admission to both Clinics. The apparent 'craving' for sleep the participants portray in their first days of admission could then possibly be linked to a lack of sleep prior to admission, either due to insomnia or poor sleep hygiene. Sleep is regarded as an occupation providing a person with rest, or rather restoration; and the negative effects of not obtaining sufficient hours of sleep, is therefore regarded as a direct result of not being 'restored' (Pierce 2003:98).

It was interesting to note that no participant with sleeping problems, mentioned using any of the above mentioned habits to improve their quality or quantity of sleep. Instead, medication was mentioned as the only strategy towards improving sleep, and is discussed as a separate sub-category in 4.2.1.2.2. Information gathered in question 20 of the biographical questionnaire, supports this category of poor sleep hygiene: all of the twelve participants who engaged in individual interviews, suggested a session on 'better sleeping' for inclusion in the group therapy program.

As indicated by Mary's comment below, some strategies used, were in contrast with the good sleeping habits as proposed by Barlow and Durand (2009:300) above.

> ***Mia:*** *(What happens) at night when you cannot sleep?*
>
> ***Mary:*** *I stay in bed. I do nothing.*

[8] Insomnia, in the present study, is regarded as the inability to obtain an adequate amount or quality of sleep (Barlow & Durand 2009:291).

When exploring the role of culture in the sleeping patterns of the Sesotho speaking adult with mental health problems, almost all of the members in the focus group agreed that their culture plays a role in sleeping, with Tsego saying:

> *You know what…before you go and sleep, you clean your house. Because you can get visitors any time, early in the morning. And the house is messed up…even when they enter – what a kind of a lady are you? So before you sleep, all the people are getting in their bed, you are cleaning in the kitchen… and when you go to the bed, it is almost 23:00 or 24:00; and everything is sore.*

Tsego and Lerato explained, and were again supported by other members of the focus group:

> ***Tsego:*** *A woman must not sleep until the sun rise…. When the chicken says – coocckallooooooooo… you must already be up, wash your hands, wash yourself and make tea for your husband.*

> ***Lerato:*** *Yes, you'll sweep outside and do anything…in the dark. It's your image. People when they are going to work by six o' clock, first thing they do, they look at your yard. They will know that this woman…it's an image.*

These comments by Lerato and Tsego were not explored sufficiently to make any assumptions from it, other than the importance of a clean house and yard to the Sesotho speaking females in the focus group.

About oversleeping, Lerato explained what would happen to the Sesotho person daring to lay in.

> *If you are sleeping in the…other room outside, they will smear (dung and mud) outside…they will use it to polish the floor. And it will take long to dry. So you'll stay there, without even the chance to get out…*[9]

In summary of this sub-category, it was established that sleeping problems are prevalent in the sample, possibly due to poor sleeping hygiene (Barlow & Durand 2009:300) and/or a diagnosis of depression(Mosotho *et al.* 2008b:176). The socio-cultural context of the Sesotho speaking adult may include some habits (such as ensuring the house is clean before bedtime); which are in contrast with guidelines for good sleep, and may therefore contribute to insufficient sleep.

4.2.1.2.2 The use of medication to induce sleep

In lieu of reporting any specific, healthy habits to improve sleeping (i.e. sleep hygiene), the use of self-medication was reported as the preferred and only method of managing sleep.

Masabatha explained:

[9]Sesotho people in rural villages may live in huts built of mud and/or clay; and straw. The floors are smeared regularly with a mixture of wet mud and dung, and needs several hours for drying before being stepped or walked on.

You know what happened…I went to the doctor and he gave me sleeping pills. I was fine, and then it started, and then the doctor gave me sleeping pills…and they did not work. That 10mg…it was supposed to make me sleep for 8 hours. But it did not work, I had to take two. And then at some point, I was taking 2 and not sleeping the whole night. And I wanted also to sleep during the day. And if I could not sleep I took a pill. Then I would sleep for 2 hours and wake up and take another pill… In the night I would maybe sleep until 1, then get up and drink another pill. That's the story of the life I was living before coming here...

Mary: *I can't sleep…I can't sleep. Maybe I (would) go to the doctor and get the medication.*

Tulane: *…when you are feeling sick…just take the medication, maybe something to sleep…*

It seems that participants look at their sleeping problems from the bio-medical point of view, with health being the 'absence of disease' (Chapparo & Ranka 2005:67). This leaves them with medication as the preferred or even only choice of inducing sleep. At the same time, the fact that participants 'complained' about not sleeping well and take what is seen by myself as desperate measures to sleep; supports Pierce's (2003:98) opinion that "sleep is the occupation for which the strongest argument for the tie between occupation and health can be made".

The use of sleeping medication may have negative effects, and Barlow and Durand (2009:298) warn that pharmacological treatment is not ideal in treating long-term sleeping problems. They confirm that people could certainly become dependent on sleeping medication and that certain medications (i.e. benzodiazepine) could cause excessive sleepiness during the day, again affecting participation in all other occupations.

To summarize this sub-category of the use of medication to induce sleep, it can be said that, in lieu of proper sleep hygiene in the study sample, medication seems to be the only alternative to improved sleep for the participants in this study.

In conclusion about the category of sleep: it seems that sleeping problems are prevalent in the study sample; and expected in the population, largely due to their reported stressors and diagnosis of depression (Fink 2009:259; Mosotho *et al.* 2008b:176). Sleep deprivation, or a lack of good quality sleep, may affect thought processes and mood; as well as the immune system, leading to impaired physical health (Barlow & Durand 2009:288). With thought processes, mood and physical health influenced by a lack of sleep, it is important to hold in mind that all other occupations (work, social participation, personal management and leisure) may suffer when a person is experiencing a lack of sleep.

With the population experiencing a lack of sleep as a problem, their only method of improving sleep is that of sleep medication, which holds its own risks such as addiction and impairing effect on participation in other occupations (due to excessive sleepiness). The use of healthy habits to improve sleep has not been mentioned by participants, and portrays a lack of knowledge on sleep hygiene, which could be a pointer for inclusion in the occupational therapy program. The

participants' cultural context may play a role on their sleeping habits, specifically with regards to the expectation of women to keep the house and yard ready for unexpected visitors and the effect this have on the hours left for sleeping.

4.2.1.3 Leisure

Leisure emerged as a strong category, with several remarks pointing to what was initially interpreted by me and the co-coders as a lack of knowledge on the value of leisure. The range of leisure activities described by participants held a few surprises for my socialised construction of this concept within a Western worldview, especially when viewed against the typical range of leisure activities as described by typical literature. I consequently had to broaden my idea of leisure beyond that of hobbies and non-obligatory activities (Hussey *et al.* 2007:121).

THEME	CATEGORY	SUB-CATEGORIES
4.2.1 Occupations	4.2.1.3 Leisure	4.2.1.3.1 Perception of leisure

4.2.1.3.1 Perception of leisure

Throughout the individual interviews, several participants reported not having any hobbies, or not having time for hobbies or time to spend in a seeming non-productive way. Some examples were:

> ***Mia:*** *Do you have any hobbies?*
>
> ***Tulane****: Not really, not really...You know, sometimes on weekends, because I work in the weeks.*

> ***Mia**: Do you have any hobbies?*
>
> ***Nthabiseng:** No, I don't. Because I don't have time.*

The apparent lack of concern the participants showed about not having time to spend leisurely, was initially interpreted as poor knowledge of the value of leisure. (The value of leisure is viewed by myself as a beneficial effect on a person's quality of life). However, it could also be that the question 'do you have any hobbies' was so removed from the population's conceptualization of leisure, that it was guaranteed to obtain negative answers.

Other, more positive responses on leisure, included:

> ***Thabo:** I usually get up, go to the gym, take a bath and go to work…get a lunch, after work I go home, just to relax, do some school stuff, watch TV…that's what I do. Weekends I don't work, I go to the gym, attend some funeral if there is a funeral to attend.(…) Sometimes you find that you have nothing to do then you end up going to the funeral. At least if you go to the funeral say, by 12 you are back…late in the afternoon you will go watch soccer with friends, have a few friends. (…) Of late I don't play. It's only to sit down, with the guys, talking, sharing some views. I don't go out to the clubs anymore. Another thing I like is to travel. I prefer to travel. You don't plan…it's one Saturday, you just decide to go to Pretoria and Sunday back to Bloemfontein…that's the life.*

Tshiamo: *I like writing some poetry, and I just started to write a mathematics book in Sesotho.*

Simon: *I play cards and darts. And I attend the meeting of friends. Over weekends. (…In the week) at night, I just watch TV, I boil water and drink the water….*

Masabatha: *I love baking, but now I am diabetic I am avoiding baking and cooking. I work as a patrol officer at the prison, but I love making curtains. Physical exercise. Stretching, jogging…making the physical exercises. I love reading books…even though I read one book for a lo-oooo-oooo-ng time* ***(laughing)***

Tulane: *When I've done cleaning my house, I like music. I like sitting around, maybe with some foods and music, I like that.*

Mia: *OK, but tonight…maybe you've had a long day on the job, what will you do tonight for leisure?*

Jennifer: *I sleep.*

Neumayer and Wilding (2005:318) describe leisure as a complex concept, which refers to more than "having fun". They define leisure as "the time to *engage freely* in a *chosen activity* that brings *value* or *positive outcomes* to the individual" (Neumayer & Wilding 2005:319). The way participants described their leisure activities, so far, certainly match this definition. The link between health and leisure is not a new one – even the Greek philosophers used the 'sound body, sound mind' principle when writing about leisure (Neumayer & Wilding 2005:321). Further, the value of leisure may be threefold: it can sustain health, and provide opportunities for self-actualisation and creativity (Neumayer & Wilding 2005:323).

In the verbatim quotes above, a range of leisure has been mentioned: going to the gym, bathing, playing games, socializing, watching TV, etc. All these activities are traditionally associated with leisure (Neumayer & Wilding 2005:319-323), at least in my mind. However, a few participants mentioned two interesting activities as their main sources of 'recreation': that of selling skincare products; and domestic work (house cleaning). Examples follow:

> ***Mary:*** *Three months back, I joined Justine and Avon, I will sell it. (…) It is for money….and I enjoy it. Because I get things for myself.*

> ***Mary:*** *If I clean my house, maybe washing…. Go outside, clean the yard.*
>
> ***Mia:*** *OK, so like some people knit, or exercise, or listen to music…is there anything like that you do?*

Mary: *Yes, when I clean my garden and my garages*

Mia: *I've heard of many Sotho ladies telling me that they clean their houses for leisure.*

Tsego: *Yes…Yes…Yes!! You know what…before you go and sleep, clean your house. Because you can get visitors any time, early in the morning. And the house is messed up…even when they enter – what a kind of a lady are you? So before you sleep, all the people are getting in their bed, you are cleaning in the kitchen… and when you go to the bed, it is almost 23:00 or 24:00; and everything*

Why is it surprising that these activities have been mentioned as leisure activities? A possible argument is that the traditional idea of leisure is that of time spent on non-obligatory, possibly non-productive, pleasurably activities (Hussey *et al.* 2007:121).

Hutton (2008:347) however, consider enjoyment as the aim when partaking in leisure activities, regardless of the activity. It was therefore necessary to scrutinize my own concept of the classification of activities and occupations, and consult sources from occupational science. Specifically Primeau (1996) and Wright (2004), provided very insightful theory which is discussed later in this section.

Hutton (2008:349) advises that leisure activities have to be viewed within the context of the culture of the person engaging in said activities. Even so, she refers to the CMOP which distinguishes between Leisure and Productivity as follows. Leisure is regarded as activities engaged in for enjoyment; with productivity the activities engaged in to make a social or economic contribution, i.e. employment, housework

and parenting. If a person is engaging in an activity for the purpose of enjoyment, even if this would be cleaning or selling products, as mentioned by Tsego and Mary, it could thus be classified by them as 'leisure'. In my own Western perspective, similar to the CMOP, I would classify these activities (cleaning and sales) under 'Productivity', in making a social and/or economic contribution.

Primeau (1996:58), however, questions the traditional categorization of occupations; whether it is sufficient if not looking at the individual experience. Work is "broadly defined as purposeful or sustained activity that is the opposite of rest; or defined narrowly as a means of earning an income and a living". These definitions lead to the Western assumption that time not spent at work, is then for leisure and self-care. Primeau (1996:59) argues that the activities a person partakes in in non-work time, is socially determined within a specific culture. She defines leisure as a "discretionary activity that is chosen and carried out in time that is free from obligations". Obligatory activities would be all the activities a person has to do for herself or others. Where, in these categories of work, leisure and obligatory activities (i.e. self-care) would we place household work as mentioned by Mary and Tsego, then? Primeau (1996:61) identifies aspects of work and leisure in household work; and states that literature indicates it is up to the individual to decide whether household work is work, leisure or self-care – according to the social meanings attached to it. It seems Mary and Tsego, then, chose household work as leisure activities, possibly but not necessarily due to the social meanings it held for them.

It seems now that we have 'permission' to classify occupations according to what the person partaking in the occupations, get from it. The question now arise – what makes the difference in what a person 'get' or 'gain' from an activity, the value they experience?

One avenue of exploration, would be the theory of 'flow'. *Flow* is described as the positive experience of getting so submersed in an activity that one forgets about almost everything else (Wright 2004:67). This phenomenon can be experienced during the performance of almost any activity that requires a high level of concentration and attention (Wright 2004:69), and may lead to an enhanced sense of well-being (Wright 2004:70).It is therefore possible that the participants experience flow in activities regarded as atypical for 'leisure time', such as cleaning and selling products.

Another very similar avenue, is Pierce's (2003) explanation of the value of occupations. Pierce (2003:45) identified three subjective characteristics of participation in occupations: pleasure, productivity and restoration. These characteristics are supposed to be seen a variable blend in occupational engagement. Pierce argues that a person's experience in engaging in a specific occupation, as well as the context in which the occupation is performed, contributes much to the value and meaning it holds for the person. Therefore, the traditional categorization of occupations as 'work, play/leisure and self-care' is rather value-laden and culture-bound and do not necessarily leave space for the person's subjective experience of the occupation.

Back to leisure: if a person experiences pleasure and restoration in any given activity, then certainly that activity can be regarded as 'leisure'? Again, Pierce (2003:45) points out that occupational therapists should allow the person engaging in the specific occupation or activity, to describe their experience, rather than evaluating the activity from our own culture-bound point of view.

Finally, it may be necessary to admit that my traditional idea of leisure as hobbies and non-obligatory activities (Hussey *et al.* 2007:121), was proved to be insufficient

for the population in the current study. This also points to the dearth of occupational therapy literature providing alternative classifications of leisure.

To conclude on the category of leisure: if Neumayer and Wilding's (2005:319) definition of leisure as "the time to *engage freely* in a *chosen activity* that brings *value* or *positive outcomes* to the individual" is used as parameter, I can infer that the participants seem to take time to *engage in activities they choose* according to the *value of leisure they attach to it.* These activities may be different from the traditional activities labelled as leisure activities, but they hold meaning to the participants, in providing 'restoration' (Pierce 2003:45).

4.2.1.4 Personal management

Personal management as occupation include activities of daily living ranging from dressing and feeding oneself, to child rearing and financial management. Reports of poor skill in financial management have been made by some participants; and this has been classified as a component of personal management, categorized as an occupation.

THEME	CATEGORY	SUB-CATEGORY
4.2.1 Occupations	4.2.1.4 Personal Management	4.2.1.4.1 Poor skill in personal financial management

Question 20 in the biographical questionnaire at the onset of each individual interview, indicated that eleven of the twelve participants suggested 'finance and budgeting' to be covered in the group therapy program. This was interpreted as an

indication of participants expressing their need for improved skill in personal financial management.

> ***Mary:*** *The other problem is financial. Maybe I have a lack of skills… because of the small money. Really I don't know. But when you enter my house, there is food, there is electricity. And every month I take the money for the taxi, for the whole month.*

Financial management is classified as an occupation; an instrumental activity of daily living (IADL) in the Occupational Therapy Practice Framework (OTPF), and defined as

> *the capacity to handle one's finances, including planning and living within a budget, paying bills and understanding banking procedures and various methods of completing transactions (Sladyk & O'Sullivan 2010:36).*

Auerbach and Jeong (2005:606) support this definition. The quotes from Mary and Tshiamo above, was interpreted as a 'lack of skills in financial management'. However, I am of opinion that the evaluation of a person's ability to manage finances remains subjective, since the person's reports on his own abilities remain the main source of information for evaluation. What is evident from the quotes above, though, is that this perceived 'lack of skills', or even the lack of finances, is causing a significant amount of unease and stress.

Another important factor, taken from Tshiamo's statement above, is the role of family members in the management of personal finances. Another quote by Tshiamo, and one from Nthabiseng, highlight the fact that participants are often

caring for more than one member of their family from their own personal salary and only income.

> ***Tshiamo:*** *I have two sisters and while I was in college, my younger sister needed some things and I gave her my credit card to buy what she needed. So…while I was in college...I was under pressure… I couldn't go to the shops to pay my credit cards. I decided to every time I get paid, I will give her the money to pay my credit cards. It was for about five months she was using the money to entertain herself…… Uh, (yes) sometimes my brothers will borrow money and they don't give it back. Yes, they always say they will give it back. Sometimes I am in a position where I only have a thousand Rand left for the month, but I know how much I need for the rest of the month. So I will sacrifice, I will give them… (...) I'm still taking care of my family. I'm still taking care of my mom, in Botshabelo. She lives with her granddaughters. Yeah she was having trouble financially so I am helping here. Physically I'm also helping her because she is diabetic. Sometimes I buy her medication.*

> ***Nthabiseng:*** *(I am) basically caring for the whole family. My sisters, my parents, my child….. My parents… my child… my siblings… three sisters and two nieces. And extended family. My dad has a job but he has too much debt…he's not just …he's always in debt. And mother is not working. I am putting my sisters through university. I want to see them…get them on their feet…especially the one with the two kids. So*

> *that she can be on her own…without being independent on me. So that even without my parents my father will be able to support my mom without us because now if I leave not they will just sink, they will not make it….*

Upon hearing several similar stories of taking care of families, from other participants as well as other Sesotho speaking adults in daily practice; I started reading about what seemed like a very strong connection between family and even community members. The concepts of a collectivist worldview[10] and the philosophy of Ubuntu were the starting point (McAllister 2009:1-10). Van der Walt (1997:31) describes the collectivist worldview as one that places a strong emphasis on interdependence and affiliation with others. The self-concept of the individual with a collectivist worldview is very much influenced by the community surrounding him. The Sesotho definition of *ubuntu*is '*mothokemothokabatho*'; translating to 'I am because you are and you are because I am' (Mapadimeng 2007:258). Ubuntu is regarded as a moral-political philosophy of life, containing certain values embedded in collectivism (Duncan 1999:7). These values may include the following: community first; interdependence and inter-relatedness, communalism and caring for others (Duncan 1999:7; Venter 2004:149). Note how these values such as interdependence and communalism, link with the quotes Nthabiseng and Tshiamo above.

In the focus group, most of the group members agreed that they associated with*ubuntu*as a philosophy of life. Lerato defined *ubuntu* as follows:

[10] A person's worldview is his assumption of life (Mkhize 2004:7). Mkhize (2004:13) identifies four components of a worldview: the person's orientation to nature, time, human activity and himself in relation to "the Other and the environment".

> *It's to live in harmony with other people. Yeah – and to have peace. To be sincere. Your pain should be mine, you know. Ja (yes), it is to help in general.*

Tsego defined *ubuntu* with examples of actions taken in the spirit of *ubuntu*:

> *Where there is need, you help. Then you find that maybe, you even go over for helping those who are needy. You know you accommodate whatever. You know, ubuntu… Yes you go over with helping…like maybe my children are grown up and are having lots of clothes. You share those. You take even those that my children likes… you go over the board. You know sometimes you are having your last R10, someone is asking for R10 – you go over the board* ***(overboard)****. You offer more…*

Perhaps this 'going overboard with helping' solves the mystery of what has been categorized as 'poor skill in personal financial management'. It is possible that these tales of caring for the whole family (in the quotes above) is based on a social and moral ethic relating to *ubuntu,* an inter-relatedness requiring them to assist their families financially beyond their available means, rather than a lack of skill in managing finances.

Hammell (2009:10) makes this powerful statement: "The ability to contribute to others is associated with lower levels of depression, higher self-esteem and fewer health problems." On the one hand, it seems that participants are gaining by contributing to others, as predicted by Hammell above. And yet, on the other hand, they report financial problems as rocks preventing their lives to flow ideally. This contradiction warns the therapist to tread carefully: providing strict guidelines on

personal financial management may not prove to be useful to the person abiding to a collectivist, *ubuntu* frame of reference.

In conclusion: whatever the reasons for a person's financial problems (poor financial management, or taking care of too many family members), it may prove to be a rock in the river of a person's life. Any rock in the river of a person's life, can prevent water from flowing optimally, which affects all other occupations e.g. work production and sleep may be hindered by worried thoughts.

4.2.1.5 Social participation

"Social participation refers to activities involving interactions with others, including family, community, and peers/friends" (Hussey *et al* 2007:122). The participants in the current study, specifically mentioned their interactions with family, friends and colleagues. (Interactions with colleagues have been discussed in 4.2.1.1). When discussing their lives as rivers, according to the Kawa Model, participants identified their families and friends as 'drift wood', translating to social support. At the same time, however, they identified the responsibilities surrounding their families as 'rocks', translating to problems or factors preventing the water from flowing optimally. These reports have been divided into three sub-categories, relating to family as a source of both support and responsibility; a lack of specific social skills and marriage.

THEME	CATEGORY	SUB-CATEGORY
4.2.1 Occupations	4.2.1.5 Social participation	*4.2.1.5.1 Family: A great source of support vs. a great source of stress & responsibility*
		4.2.1.5.2 Psychosocial life skills:

		poor communication in marriage poor skills in assertive communication & conflict management
		4.2.1.5.3 Marriage: divorce and unfaithful partners

4.2.1.5.1 Family: A great source of support vs. a great source of stress & responsibility

In the biographical questionnaire proceeding the Kawa interviews, participants indicated which life-roles they currently occupied. The majority of participants indicated that they were somehow involved in families, either as parents, children or siblings.

Participants described their families as a source of both stress and support, as seen from the quotes below.

> ***Jakes:*** *I would say despite the fact I have the issue that my boss is against me, and my family is giving me heartache, headache actually….my friends are giving me pressure, and myself is also giving me the pressure. I would say somewhere somehow my friends, my family, my work, my boss….honestly speaking, they were realistic in some instances, they are my pillars.*

> ***Daisy:*** *Hmmmm….My family is not supportive …because uhm…they are supporting me now, because I told them that there were problems. At first I didn't want to tell them because I didn't want them to hit my husband for the things that he was doing to me, so I just kept quiet and pretended that everything was fine and say only good things about him [her husband]. But now since I've told them, they are asking me how I am, even giving me advice about what to do.*

> ***Nthabiseng:*** *Well I do have support… my job… I suppose and my family….. my responsibilities are too much. I am basically caring for the whole family.*
>
> *Yes, I forget about myself* ***(laughs weakly)*** *I just want to have a life as well.*

> ***Tshiamo:*** *Oh, my responsibilities are huge. I'm still taking care of my family.*

The familial stressors reported by participants, all had to do with the responsibilities of taking care of their families. Only Jennifer highlighted the idea that the support received from family members may be conditional, or based on what they might gain from supporting her.

> ***Jennifer: (talking about her family and whether they would support her whilst in hospital, or not)*** *Jaaaa….it depends on*

> *the type of support that you give to the family. If really there is something they benefit much from you, that is when they will show you the support. But if they feel that no…they are not benefitting…no, at times they will call and say 'get well' and in some instances they will just leave you like that until you are healed or you die. That's the way…*

Once again, as in all the previous quotes, the themes of interdependence and inter-relatedness, and caring for others, are featuring (Duncan 1999:7; Venter 2004:149). These themes are grouped in *ubuntu,* which is believed to be relevant to the population – based on their reports of collectivist nature. The main notion of *ubuntu,*'I am because you are and you are because I am' (Mapadimeng 2007:258), points towards an interconnection between the Sesotho person and the people around him. Acknowledging this interconnectedness is also a declaration of *needing* each other, another aspect of *ubuntu* that is pointed out by Walaza (2011). Barlow and Durand (2009:62), writing about the interpersonal factors affecting a person's psychological functioning, support this philosophy of *ubuntu* without intending to: "The greater the number and frequency of social relationships and contacts, the longer you are likely to live".

In summary - it seems that in this study sample, it is second nature to care for more family members than only your own spouse and children. In other words, it seems to be generally accepted for a person to *need* and consequently have a family member to take care of him/her financially and in other ways…but always in the way of *ubuntu.*.

4.2.1.5.2 Psychosocial life skills

The biographical questionnaire contained a question on which topics needed to be covered during group therapy (question 19); and which topics a participant would suggest for inclusion in the group therapy program (question 20). Participants indicated all the topics currently in the occupational therapy section of the group therapy program to be essential, including and highlighting interpersonal, social and assertive communication skills.

During the Kawa interviews, participants reported what was interpreted as a lack of specific social skills.

> ***Mary:*** *What makes the water dry…in my river? Lack of communication… with me and my husband.*

> ***Nthabiseng:*** *Maybe I should learn how to say no – because that was the problem with my past friendship.*

> ***Tshiamo:****It's not so easy (to stand up for myself), because of my background where I was born. I was like being…. Not appreciated at home, most of the time. So I didn't have the freedom of speech while I was young. Like, maybe a child may have access to talk a parent, I didn't.*

It was evident from several of the vignettes on work and marriage, that participants may have been lacking effective interpersonal skills. Roberts (2008:364) explains

that the strong and labile emotions; and negative content of thought (all associated with the mood disorders), may interfere with a person's application of interpersonal skills. This explanation may confirm this category of lacking psychosocial life skills in the study sample, who are suffering with mood disorders. At the same time, Bezuidenhout (2004:8-10) describes how family disorganisation could also impact negatively on interpersonal communication. It is beyond the scope of this study to question the order of events: do poor communication lead to a breakdown of marriages, or do the breakdown of marriages lead to poor interpersonal communication... and where do the impact of the population's mood disorders fit in? In the end, it is acknowledged that poor psychosocial life skills are causing the population significant distress, and is therefore regarded as the issue at hand.

Specific skills that myself and both co-coders observed to be lacking in the sample, included conflict management and assertive communication. These and other skills of social interaction, are regarded as essential in maintaining healthy relationships in people suffering mental health problems, and are therefore indicated as possible goals of intervention in the study population (Roberts 2008:361).

Life skills training in occupational therapy often entails group therapy and role play (Duncan 2005:262).

A comment by Moreng portrays something of the value of group therapy:

> *The groups to me is a healing.*

At the same time, if the population abides to *ubuntu* as a life-philosophy, I can carefully assume that group therapy is an appropriate therapeutic modality, since it facilitates interconnectedness and allows patients to experience something of a 'community' in hospital.

Tshiamo highlights an important issue: that of respect for one's elders.

> *If there is an argument (role play) in group therapy the therapist need to respect that younger people should respect the elders. I am 29, I cannot argue with a man who is 40.*

This single comment cannot be taken as a blanket-rule for future therapy. However, it points once again to the necessity of being culturally sensitive. It may be helpful to refer to a suggestion taken from Lim (2009:85): whatever information I think I have on the culture of a patient, has to be verified with the client, who can then also supplement my information.

4.2.1.5.3 Marital dysfunction

In the biographical questionnaire proceeding the Kawa interviews, participants indicated that all but three of them (two divorcees and one widow) were involved in relationships. At the same time, they had the opportunity to indicate which life roles they experienced as problematic. All who indicated they were involved in a romantic relationship (married or casual), also reported experiencing problems in this specific life role.

Participants identified the following rocks in their rivers, expressly relating them to their romantic relationships: a woman living with an abusive husband; a marriage being dysfunctional overall, being sued by an ex-spouse for paying maintenance; being separated from a spouse and not being allowed to see his children.

This summary of rocks preventing the flow of life, was also supported but Nthabiseng's observation:

> *We talk as patients, and I've realized that a few have work problems like me…But basically it is family, marriage, divorce, it is painful…and child support.*

Bezuidenhout (2004:16) warns that the process of divorce provides much emotional trauma to all members of the family involved. It is therefore not surprising that so many participants reported matters surrounding divorce and separation as rocks. Along the same lines, Mosotho (2005:19), in his study of 100 Sesotho speakers diagnosed with depression, also discovered marital and family dysfunctions as stress factors playing a role in the development of depression.

Several factors for marital and relationships problems were mentioned, even described as causes of divorce. These factors were unfaithful partners, abuse, lack of communication and a shift in gender roles within the culture of the Sesotho person. Each factor is reported by means of a verbatim quote from a participant, and then discussed against the backdrop of relevant literature.

Bayo introduced the first factor, that of unfaithful partners.

> *Die eerste een (wys na grootste klip) is die grootste probleem…is die man wat my 'cheat'. Hy staan in my pad in. nou die water kannie onder lekker loop nie…* ***([11]Translation to English).***

[11]**Bayo completed the interview in both English and Afrikaans. For ease of reading, the comment is translated as follows:** "The first one (showing to the largest rock) is the biggest problem...it's the husband cheating me. He is standing in my way, now the water cannot flow nicely..."

Bayo did not identify any one specific emotion relating to her husband cheating her, but it is possible that she was feeling humiliated by the situation (Bezuidenhout 2004:15).

Daisy reported that she was being abused by her husband. She later shared that she could not tell her family, out of fear that they would hurt her husband. (This idea of family involvement in the settlement of relationships problems, is discussed later in this section).

> *There are different kinds of abuse. Emotionally, physically and financially.*

At the time of the interview, Daisy was still married to her husband, whom she reported to by violent. However, Bezuidenhout (2004:21) identified violence as one of the causes for divorce. It can therefore be expected that Daisy was experiencing considerable distress in the face of being abused by her husband.

Mary reported, by means of more than one example (only one is retold below), how a lack of communication between herself and her husband, proved their marriage to be a rock in her river, preventing her life from flowing optimally.

> *Lack of communication. (...) I don't know. Because he do those things…he don't tell me nothing. Sometimes even if he were from Namibia, where he work… I can see him, tonight the car entered in the yard…How…my husband. He fly. To Namibia and here and say nothing. Aow...*

In the focus group, Lerato, Tsego and Jennifer explained how their culture impacted on their marriages.

> ***Lerato:*** *But with Basotho's, they will…they are jealous about their children, they are over protective.*
>
> *More than one member laughs in confirmation*
>
> ***Lerato:*** *That is why when the father of Mosotho will say, if this is his house, but he will say – his son is his home. He will say that. He can control his own home and his son's home.*

> ***Tsego:*** *My mother-in-law is controlling my house. Is controlling my husband. And then…somewhere somehow, I will tell my husband can't you forget a little bit about your mother…can't you remember what the Bible is saying – you will leave your mother and have your wife and then you and your wife* ***(clap hands together****) will be one thing. He will say – you know what? My mother is my mother. And my father is no longer care there to take care of my mother. So I'm the head of the house. So you will find….that I'm nothing. That is when you start…I take all the things in my head, I'm nothing in front of you I'm nothing, you see? And that puts the stress on you.*

Jennifer, during the focus group, opened the topic of a shift in gender roles, and the unavoidable, entropical resistive forces toward a shift for more equality in marriages and relationships.

> ***Jennifer:*** *That in Lesotho, uhhhhh – the man is the father figure, he is the head of the family… The way society is built, we have to abide by what the man says and does….we just*

have to follow. Unfortunately, it is not like in the past…whereby men went to work and the woman had to stay at home and look after the children and all other family chores. These days, we have to work, we have to plan together. And unfortunately, that is a big problem, because that respect is no more there. In the past it had to be there, because the father had to provide everything. But, of late, you find that women occupy better professions than men, and in most cases when it comes to financial deliberations, women would have more income than men…in a way it makes men feel like they are all but nothing. Or they don't have the power they used to. So that really creates a problem. Hence why you find that in most cases, some of us are here because of the interactions, that males would say you think you are better…blablablabla. On the other hand, women would not be able to respond too… and men in most cases they want to fight physically and women, they want to talk…

More than one group member: *Hmmm...Yes...(nodding heads)*

It seems that Lerato, Tsego and Jennifer reported more than one factor of contention here. Lerato talked of over-protection by the both sets of parents. Tsego explained how her household is still very much influenced by her mother-in-law. Jennifer testified how she is expected to fulfil her role as wife in ways customary to her culture, whilst she is involved in the working force - a role less customary to her culture (Pretorius 2005:373). These factors all have to with 'culture', and even

though Bezuidenhout (2004:18-21) points them out as stressors marriage and possible causes for divorce, it is expected of Lerato, Tsego and Jennifer to carry on like this, as it is part of their culture.

Apart from identifying marital problems and divorce as rocks in their rivers, even as reasons for admission with Major Depressive disorder, participants did not give specific examples of the effect thereof on themselves. Simon, however, was very explicit about the effect of his recent divorce on his behaviour.

> ***Simon:****(But then the) time when there was something of divorce, I started with brandy. I didn't mix it. And I smoked.*

Bezuidenhout (2004:9) confirms that family disorganization, of which divorce is one of the more final and extreme forms, may lead to substance abuse. The other side of the coin is that substance abuse may lead to Major Depressive disorder (Barlow & Durand 2009:394; Mosotho 2005:18) as it is possibly the case with Simon. He was admitted to The Clinic with a dual diagnosis of Major Depressive disorder and alcohol abuse.

Another point of contention, which might have a direct impact on the therapy provided to a patient reporting marital dysfunction, is the way the Sesotho speakers report their handling of their marital problems.

> ***Thabo:*** *(Participant firstly explained how his marital problems started with his wife complaining about his long working hours)*

At one stage I tried to bring in my mom she called us – she put us down and said, let me hear both sides of the story. We both told our stories and then my mom said, now – this is the way you should go. That was not the problem as such, the problem was that from her family, there are sisters that are not working - that are depending on her. So they were forcing her to make certain decisions without consulting me, so that was the problem…we tried to solve it but we couldn't. And when we were about to settle the issue of the support, she moved out of the house, to a place separate from mine. (...) You know, the problems between me and the wife… but now, her family is involved. (...) I tried to bring in the parents, that can be of assistance, it didn't solve…

Mphohadi:*...we asked my senior (colleague at work), to organize a chaplain for me and my wife. But so far the chaplain didn't arrive. Then we organized…my wife went…she went to a court, this person who deals with marriages? That father from the court came to my house. He didn't call us to the court, because he said he didn't want the people to say – that happy family, is just happy on the outside. The inside is broken. He said, rather than calling us to court he will come to us. So he can discuss, discuss, discuss with us…. I took out my problems, she took out her problems, and that guy came with some solutions. Then we wrote those things with my wife. Even though it is not 100%, up to so far, it is going well. she is the one who phoned Dr. M…and said, my husband is*

> *not well, I want my husband to be admitted. And I will make sure to bring my husband here….*

Mphohadi and Thabo explained above how family members (specifically parents) and possibly other elders may become involved in the attempt to solve marital problems. Mphetolang (2009:47) and Sesanti (2010:349) confirm that elders becoming involved in this kind of situation, is a part of *Botho (Ubuntu)*[12]*,* a way of life described as characteristic in the Sotho-Tswana people. This mitigation by elders would be done in order to bring peace in the whole interconnected community. On the other hand, Bezuidenhout (2004:19-21) points out that involvement from in-laws, and other outsiders (i.e. the elders), may cause extra marital conflict which may even lead to divorce.

In the final analysis, it seems that the social participation of the participants provides a dyad of perceptions. Participants reported their social circles to be driftwood or support; whilst they identified the responsibilities surrounding their families as 'rocks', or factors impacting negatively on their lives. Other reports and testimonies by participants, lead me to believe that they hold the philosophy of *ubuntu* at least to some extent. This is seen in the interconnectedness they experience with the people around them (c.f. 4.2.4). The responsibilities that are involved in supporting their families are many, and provide much stress. At the same time, it was evident from many of their tales about taking care of their families, that their psychosocial life skills were limited, specifically with regards to assertive communication. The question remains whether assertive communication would be allowed within the boundaries of certain cultural customs. (In 4.2.4, the discussion of the sample's

[12] *Botho* is the Sesotho term for *ubuntu* (Sesanti 2010:348). Since *ubuntu* was the term introduced by participants, I chose to carry on using it throughout this document.

socio-cultural context, may shed some light on this question.) Also, their marriages seem to be influenced by certain cultural customs, leading to marital dysfunction and psychological discomfort.

4.2.2 Emotions

Throughout the individual interviews as well as the focus group, I came under the impression of participants feeling a sense of being overwhelmed by their responsibilities and/or their personal situations; or experiencing feelings of depression.

THEME	CATEGORY	SUB-CATEGORIES
4.2.3 Emotions	4.2.3.1 Feeling overwhelmed and/or depressed 4.2.3.2 Experience of emotional relief after talking	

4.2.2.1 Feeling overwhelmed and/or depressed

The sense of feeling overwhelmed was most explicitly expressed in participants' descriptions of their lives as rivers.

> ***Tshiamo:*** *I think my river looks like a flood. Because I'm having so much problems…instead of about to be healed here today, some of these problems … it seems like I'm getting a new problem every day. That's why I'm saying it is like a*

*flood…it's too much. If I have to name them…**(thinks for about 20 seconds)**…my heart is full of hatred and anger.*

***Bayo:** Ek dink hy loop net so…raserig. (Translation to English [13]).*

It was interesting to note that, in literature on the Kawa Model, no rivers 'in flood' are mentioned. Rivers are only described as flowing well, or flowing catastrophically slow and even dry, i.e. "without water flowing, there can be no river" (Iwama 2006:144 & 154). However, Iwama also states that the model is used in the 'right' way, if it can illuminate the client's narrative. From Tshiamo's statement above: "I think my river looks like a flood. Because I'm having so much problems", it is clear that he is feeling overwhelmed by his problems, even helpless in the face thereof, and the Kawa Model served as an effective vehicle to deliver his narrative. In lieu of using the phrase 'feeling overwhelmed', as used in the present study, Hicks (2005:94) mentions the fact that a person suffering with depression "carr(ies) the weight of the world on (his) shoulders". This seems to be in line with feeling overwhelmed, as was apparently experienced by both Bayo and Tshiamo. Mosotho (2005:22-23), whose sample of 100 Sesotho speakers with depression shared many biographical markers with the sample of the present study, also added the following secondary psychological symptoms as reported by his participants: emotional turmoil, emotional misery, panic and suffocation. These secondary symptoms of depression, as reported by Sesotho speaking adults, are also in line with the feelings of being overwhelmed described above.

[13] **Bayo:** I think it flows so…noisily.

Several participants described their rivers as not flowing, with the water standing still or drying up; a sign of experiencing some kind of "disharmony" (Iwama 2006:144), in this sample probably indicating a depressed mood.

> ***Mphohadi:*** *In my river…I think the water is just standing. And I think underneath the water it is so dark. And maybe there can be something in that water. Because if my river, if it was a flowing river…maybe I could have find myself in a certain stage of life. Now because the water is standing still here am I again.*

> ***Nthabiseng:*** *But I feel that my water is not flowing (tearful)*

> ***Thabo:*** *There is not enough water…*

> ***Mary:*** *It is dry...*

Hicks (2006:995) states: "Life slows down during depression", an opinion which certainly resonates with the statements above! Some words that are used in literature to describe a depressed mood, include sad, heavy, empty, hopeless, joyless and fatigued (Hicks 2005:93). These words hardly bring to mind the picture of a clear and fast flowing stream, but rather match the descriptions of slow and even dry rivers.

To put the above reports of feeling overwhelmed and/or depressed in perspective, literature on mental health problems have been consulted. The diagnosis which at least 10 of the 12 participants from The Clinic reported, was Major Depressive disorder. Literature (Barlow & Durand 2009:208; Hicks 2005:91-94) further confirms both the emotions of being overwhelmed and/or depressed as congruent with mental health problems, specifically the Major Depressive disorder. The DSM IV-TR criteria for a Major Depressive Episode, also include symptoms such as a depressed mood; lack of interest in daily activities, psychomotor retardation or agitation, fatigue and feelings of worthlessness (Barlow & Durand 2009:208).

In light of the reports of having too many responsibilities regarding families, it would be interesting to understand more about the order of events. Does the load of responsibilities lead to depression; or does depression lead to the perception that one is not coping with responsibilities? Whichever comes first, is not an aspect covered in this study. It would however be considered that either experience (depression or too the perception of too many responsibilities) could catalyze the other.

4.2.2.2 Experience of emotional relief after talking

Three verbatim quotes are available on participants stating how much it helps them to talk about their problems. However several others, following the interview, whilst greeting the therapist and leaving the interview room, also verbalised their positive experience of having the opportunity to discuss their lives (the individual interviews).

> ***Nthabiseng:*** *And it* ***(the individual interview)*** *has helped me as well, because I need to let it out…*

> ***Thabo:*** *The problem is that I've learned that being quiet doesn't help. So rather say your emotions and how you feel… it does help.*

> ***Mary:****My mother and my sisters. (...) We can talk, we share.*

Hicks (2005:100-102) regards psychotherapy as insufficient as sole therapy for severe depression; but more effective in mild to moderate depression. He describes the major advantage of psychotherapy as the opportunity to gain perspective by having another person listening to and verifying your feelings. Barlow and Durand (2009:243) specify cognitive-behavioural therapy and interpersonal psychotherapy as effective treatments for depressive disorders. With psychotherapy being outside the scope and aim of occupational therapy, therapists may choose to use certain cognitive behavioural or interpersonal strategies in aiming for changed behaviour in the patient (Cara 2005:181). However, what participants experienced in the interviews, was not pure psychotherapy, but merely having the opportunity to ventilate their feelings and feel understood by a dedicated listener. The therapeutic value of talking has been discussed even since the classic philosophy of Plato and Aristotle.

With specific regard to the Kawa Model, Iwama (2006:167) describes that many therapists have commented on the usefulness of the model to facilitate a discussion of the client's life situation. This usefulness may be embedded in the fact that the therapist is literally aiming to get a 'picture' of the client's life, which can make the client feel understood, which in turn could be a positive experience for said client (Iwama 2006:166).

With the above quotes and literature referring to individual interviews and therapy; it was interesting to bring in the opinions of William and Moreng, both patients at The Second Clinic.

> ***William:*** *Within the groups, I learned that if you are a person – you join other people and when you are talking, you release something of yourself. Talking has helped me a lot. It has helped me a lot.*
>
> ***Moreng:*** *The groups to me is a healing. And to me I am starting now to introspect. I am seeing my mistakes, it is something I've grasped. I've told myself when I leave this place, I must change. I know what to change now. And I can feel…but to be here, I've made certain decisions. I feel something is coming now, on the right track.*

What may be playing a role here, could be the therapeutic factors of groups. Universality (realizing that I am not alone!) and the instillation of hope (change is possible!) are two important factors, both promising emotional relief, evident in the quotes above (Cole 2008:323).

In conclusion of 'emotions' as a category: the sample seems to experience feelings of being overwhelmed by circumstances, and depressed. Both these feelings are associated with the diagnosis of Major Depressive disorder, from which most participants suffer. With regard to getting relief from these feelings, participants did not report any apparent culturally specific ways of dealing with it. Several of them, however, reported feeling relieved after discussing their narrative.

4.2.3 Values

Values are defined by Gross in Lim (2008:259) as 'a sense of what is desirable, good and worthwhile'. In the current study, values could be interpreted as things that are important and therefore of value, to participants. Quite a few values were expressed throughout the interviews, with four reported as categories, due to the great emphasis placed on it by many, even most, of the participants.

THEME	CATEGORY	SUB-CATEGORIES
4.2.2 Values	4.2.2.1 The importance of a positive mindset (optimism[14]) 4.2.2.2 Involvement in family 4.2.2.3 Involvement in community structures & activities 4.2.2.4 Spirituality and religion	

4.2.1.1 The importance of a positive mindset

Comments on the importance of having a positive mindset were made by many participants, and four examples are reported:

> ***Tulane:*** *You know, obviously in life, there is no things that is gonna run smoothly… they go up and down. You see…although, you must be responsible enough in whatever*

[14] Optimism is the tendency to expect that "good things rather than bad things will happen to the self" (Taylor & Stanton 2007:380); and it is a construct used in psychology. **Mindset** - a habitual or characteristic mental attitude that determines how you will interpret and respond to situations

you do, and positive, so that maybe you can achieve your goal. But to be negative…you will always be depressed by so many things. But if you have a positive mindset…even if you haven't achieved some of your goals, but…you must have that room that one day, you will have those things.(…) I carry on with my life…if people talk about HIV, I participate…I tell them, I am positive (HIV positive). I don't have stress, I don't want to lie. I always pray God to give me strength. And I've got other friends, they are positive (HIV positive). And I talk to them…sort of counselling. They are living like myself.

***Thabo** (talking about a friend he regards as a brother): We support each other. We try to say – this is life how do we approach it. There are some problems along the way but it is easy when you have someone to talk to… (…**) (Later, when talking about the 'rocks' in his river)**: Yes, but at this stage – even though they are rocks… I think I am on the way of saying – I am not going to ignore them and pass them. I'm in the process of dealing with the rocks. Removing them. Because if you skip them, you might have to face them again. So I am in the process of dealing with them.*

***Jakes:** One of the things that make me sad sometimes, I once read a book from Leo who was stating that happiness is acknowledging and appreciating the little things that we have; and not wanting the things that we don't have. Then I*

felt that…if I was appreciating, I would not find myself in trouble. If I just had to appreciate and did not nit-pick and develop a negative attitude towards people who were trying to assist me, then…. That's part of life actually. I would say it is a season. It was my season of badness, but now it will pass…. (…) The good thing that I know of…with myself, is that I know that I can think, and I can think big. And I know that my thoughts most of the time, helped me to escape lots of things that were supposed to happen to me. So the good thing is that I still believe I have the potential in spite of whatever happened.

Masabatha: *You have to put yourself right in here (shows to the head). And they physical part listens to this (again points to her head)…if you are depressed it does not want to do anything it's tired. If this is not working, the body is also not going to work…*

A positive mindset is regarded in the present study as the habit of positive thinking, which has an effect on behaviour. Optimism, as a psychological construct, is the expectation that good things will happen to oneself (Taylor & Stanton 2007:380); and is therefore closely related to the idea of a positive mindset. Literature on optimism describes it as a coping-resource, allowing a person to "manage the demands created by stressful events" (Taylor & Stanton 2007:377). In being a predictor of behaviour and a coping-resource, in can also contribute to physical and mental health (Gable & Haidt 2005:105; Krypel & Henderson-King 2010:413). Optimism correlates with the use of problem-focused and emotion-focused coping

responses and resultant lower levels of psychological stress, whereas avoidance or disengagement coping strategies correlates with higher levels of psychological stress (Krypel & Henderson-King 2010:414; Stasiowski 2008*:online;* Taylor & Stanton 2007:384*).* It is important to note that optimism as a personal trait, can be depended by genetics and individual physiology (Taylor & Stanton 2007:381 & 386 , and that it can increase with cognitive-behavioral therapy (Taylor & Stanton 2007:390).

On a less positive note, Temoshok, Wald, Synowski and Garzino-Demo (2008:556) warn that "unrealistic optimism may reflect a repressive coping style" and that "optimism in the absence of positive coping skills may result in greater disappointment or distress when negative life events inevitably occur". This view of optimism urged me to look at the verbatim quotes above once more.

The following excerpts from the quotes above, may point to optimism as a 'choice' and a value in these two participants, rather than a personal trait, which in turn may reflect unrealistic optimism.

> ***Tulane:*** *You see…although, you must be responsible enough in whatever you do, and positive, so that maybe you can achieve your goal. (Emphasis own)*

> ***Masabatha:*** *You have to put yourself right in here (shows to the head).*

If what we see above is unrealistic optimism, it may once again point to the necessity of learning to employ constructive coping skills, which makes out an essential part of an occupational therapy program.

4.2.2.2 Involvement in family

Involvement in families were often described by participants as rocks in their rivers of life, but at the same time they also regarded their families as being part of their river walls: their support systems. This duality is discussed in 4.2.1.5.1. What is relevant now, is that it seems the sample regard family involvement as 'desirable, good and worthwhile' (Gross in Lim 2008:259) and therefore holds it as a value.

The category of involvement in family as a value held by the participants, has not been included based on a number of verbatim quotes. It was rather a matter of an overall impression from all interviews; including the verbatim quotes that indicated families to be a source of support as well as stress (c.f. 4.2.1.5.1). Also, in hearing their narratives according to the Kawa Model, family was indicated as an important part of life: a value.

Several participants reported their families, or members of their family, as pieces of driftwood in their rivers. (Translating to transient, positive resources). Similarly, many participants described their families, or members of their family, as part of the walls of their rivers, translating to social context, hinting that a person is formed by specific environments.

When describing their families, it seemed that most participants were part of extended family structures, rather that nuclear families comprising only of two spouses and the children (Ferraro 2001:203).

A last aspect regarding family involvement as a value, is that it may be implied by *ubuntu,* should the participants hold *ubuntu* as a philosophy. This matter will be discussed in 4.2.4.3.

4.2.2.3 Involvement in the community

Of the 12 participants being individually interviewed, at least eight identified specific roles of involvement in the community. These roles include being a community leader – in a political party or a crime prevention unit; being part of the Community Policing Forum; taking part in Lovelife; acting as a foster parent, or filling the post as secretary in a soccer club in Mangaung. Other roles mentioned included being a member of a soccer club or a 'stokvel'[15].

Masabatha, in spite of the challenges of living with diabetes and working nightshifts as a correctional officer in a correctional facility, was most expressive about her passion for community involvement.

> ***Mia:*** *What challenges you?*
>
> ***Masabatha:*** *It is getting out. I need to get out, meet with the learners in Lovelife, motivate them, talk to them about their problems, show them that there is another side of life. They don't have to do things that they are not supposed to do; listen to them, hear them telling me their problems…trying to solve their problems, and motivate them. That gives me life!!!*

[15]'Stokvel': a savings pool or syndicate, usually among Black South African people, in which funds are combined for mutual support or entertainment.

Clary and Snyder (1999:157) identified several functions experienced by the volunteer. The first function would be the enhancement of self, i.e. 'I feel better about myself'. Secondly, through protecting and teaching others, I can escape from my own troubles. (Notice how Masabatha said – 'It is getting out', possibly referring to getting away from her own troubles). Thirdly, volunteering could provide a platform for expressing my values such as "I feel it is important to help others". It seems that Masabatha may have been experiencing all these factors, but her statement containing so many verbs "I **need** to get out, **meet** with the learners...**motivate** them...**talk** to them...**show** them that there is another side of life" seemed like a rather passionate expression of a personal value of community involvement.

Tsego opened the topic of *ubuntu:*

> *Where there is need, you help. Then you find that maybe, you even go over[board] for helping those who are needy. You know you accommodate whatever. You know,ubuntu…*

Lerato then described *ubuntu*, a philosophy possibly explaining this value of being involved in the community.

> *It's to live in harmony with other people. Yeah – and to have peace. To be sincere. Your pain should be mine, you know. Ja, it is to help in general.*

In 4.2.1.5, it was speculated that *ubuntu* may be a philosophy held by participants in this study. The statements above, made by Lerato and Tsego, were supported and acknowledged by more than one group member.

Also, the activities associated with involvement in the community, as mentioned and/or described above, are confirmed by Mabovula (2011:45) to bind community members together in a way that resembles *ubuntu. Ubuntu* considers one's interconnectedness to others, with involvement in community being a very good example of this connection to others. It is therefore carefully assumed that *ubuntu* is the philosophy underlying this value of community involvement (Krog 2008:353).

4.2.2.4 Spirituality and religion

Individual interviews revealed that participants value spirituality and religion as a value: something 'desirable, good and worthwhile' (Gross in Lim 2008:259). The questionnaire in the onset of the individual interview schedule (Appendix B) contained a section where participants could specify their religion. The list of options read to them included the following: Christian - Evangelical or Protestant, Christian – African Traditional (ZCC), Roman Catholic, Islam, Hindu, Other and None. Of the eleven participants, nine indicated that they were Christian (Evangelical or Protestant) and two that they were Roman Catholic. It seemed that participants in the focus group also held spirituality and religion as values, although they expressed their struggle to reconcile their culture with 'modern religion'. (This facet will be discussed later in this section 4.2.2.4.)

Firstly, citations on spirituality and/or religion, follow:

> ***Moreng:*** *I believe in prayer, in fact. And I pray almost daily.*

> *Nthabiseng: The support also included…uh…the church. It is also a rock. (She then explains that she stopped going to church since she was not feeling welcome anymore, after an*

incident she only described vaguely.) I want my daughter to grow up going to church with her mama. So it is a problem because my spiritual life is not growing anymore. It is standing still.

Masabatha: *You know what… God is great, and I've learned how to deal with those things and how to manage them, and I am really not angry. That fact that I know God is with me…is opening doors for me…is helping me…is helping my siblings. God is always with us. It keeps me going.*

Tulane: *Yeah! It doesn't matter when the storm comes, or whatever… like… let me make an example. Uh….my husband died in 2005, and I've realized that he was HIV positive. And then I've decided to go – because actually I was ill – then I decided to do some tests – just to find out what was wrong with me. It wasn't easy, but I just thank God that just gave me strength. That whatever the outcomes, I must just accept it. (…) I always pray God to give me strength. (…) At least God gave me the second chance, to live, so that I can look after my son and myself.*

Tsego, who was admitted to The Second Clinic following a failed suicide attempt, testified how she expected God to protect her children from going through a similar experience:

> *I thank God really because if something was happened I could have died. (…) But it is genetic, my father also committed suicide. He was a teacher, he did commit suicide. And that is genetic…so I must take it out, and pray a lot, and this thing must not come to my children.*

Simon explained his marital problems and then proceeded to explain how he will involve the church in salvaging his marriage:

> *I decided to go out the weekend, to the church. I will get the priest, and ask him to talk to us. (…) When we go to the church, then we must tell the priest everything…if he say we must unite again, we must get counselling first.*

From the quotes above, it can be noted that participants seem to gain strength and support from their experience of spirituality and/or religion. Religion, in the present study, is regarded as the more organized and formal aspect of expressing spirituality, i.e. rituals and ceremonies (Dein, Cook, Powell & Eagger 2010:63). Spirituality is regarded as part of the contexts in which a person's lives; and more specifically defined as the "orientation of a person's life – that which inspires and motivates that individual" (Hussey et al. 2007:124). Spirituality is a connection to the self, the rest of humanity and the universe; a connection that provides a background to a person's search for meaning in life (Algado & Burgman 2005:249; Pierce 2003:109). From this viewpoint of spirituality as a connection, it can be said to have a wider meaning than that of organized religion, and may therefore influence every part of an individual's existence and his participation in occupations (Hume 2008:390). The occupational therapy process is therefore also concerned with spirituality as context (Blair et al. 2008:27), and considers spiritual experiences as

"highly restorative" (Pierce 2003:109). Law and colleagues (Hussey *et al.* 2007:204) also placed spirituality in the centre of the CMOP, since it motivates and inspires a person in all other aspects of occupation.

On a more practical note, Eckersley (2007:S54) identifies the benefits of religion for one's health, as social support, and a sense of purpose and meaning sheltered in a coherent belief system. In summary, Dein *et al.*(2010:62) acknowledge spirituality and religion as "coping mechanisms in managing stressful life events".

In the focus group, with the main question being 'What do I need to know about your culture?', the discussion very soon veered to the topic of death and mourning rituals, and then to a link between culture and religion. It seemed the group members regarded their "change in religion" as Olivia states below, as a marker of a changing culture (cf. 4.2.4.1.2).

> ***Olivia:*** *Yeah – I was saying that the difference now to the old days is the change in religion. Because we are still black, and Sesotho. But you'll find that the religion that I believe in doesn't allow me to do certain things from my culture… (Several members of the focus group 'mmmmm' in agreement) So, the…the…the…the…..the religions that are there now, are changing us….are taking us from our culture. Because then if you go to some church, they tell you that's not your mother…that's an evil spirit. Meaning your mom's grave. So difference is made by the religion.*

> ***Tsego:*** *You go to the different religion, and they tell you, don't believe in ancestors. Don't go and pray to them. (…)Buy you will mix…you will see…other people…I am sorry but I will say it to your culture. (Referring to the researcher, being white and Afrikaans.) They are still visiting their ancestors. They are going with the flowers, they will clean the grave. The grave is so neat. And the grave is so neat and they will still visit. And then you ask yourself…but why whites, they didn't change? Why us, why did we change? (…) And the religions change us a lot, because I go to this church where they say you must not slaughter, and not make some feast… And then I know when I was growing up, my grandfather, my father…they were slaughtering a goat, and then we would bring this feast, we were doing a sorghum beer, and at home we would make some 'motogo', we'll do what….and even make some spinach or some dumplings, there's no rice but the dumplings will be there. Why I have to change?*

Eckersley (2007:S54), who was previously quoted on the benefits of religion, warns that cultural values may influence spiritual expression in religious set-ups. This can lead to individuals experiencing "tension, conflict and confusion when they run counter to religious beliefs and teachings, making it harder to integrate religion into their lives" (Eckersley 2007:S55) – as is supported by the quotes of Olivia and Tulane above.

In conclusion about spirituality: it seems to be a value dearly held by the participants. However, as Eckersley (2007:S55) warns above, it may cause considerable distress for participants to try and merge their cultural beliefs with their religion.

To summarize this section on the values of the participants: they reported a positive mindset as so important, that I saw the warning lights of repressive coping styles. Secondly, their involvement in family and the community was highlighted as very important, and possibly linked to *ubuntu* as life philosophy. In spite of this high premium on a connection to other people, they also regarded spirituality and religion as an important facet of life, albeit in contention with aspects of their culture.

4.2.4 Socio-cultural context[16]

Data on the socio-cultural context of the Sesotho speaking adult with mental health problems, has been collected from three sources: the biographic questionnaires; individual interviews and the focus group interview.

I expected to find cultural values and beliefs that influenced occupational participation, and was not disappointed. However, I was surprised to discover in both samples much confusion regarding their own culture and the influence thereof on their daily lives.

With regards to culture, four categories have been identified. The first describes the nature of the participants' culture, and the second describes some of the customs associated with being a Sesotho speaker. The influence of being Sesotho on social

[16]For the purposes of this study, the following definition is used: socio-cultural context refers to a patient's ethnicity, life roles and tasks, attitudes, customs, habits, beliefs and values. Hussey *et al* .(2007:124), supports this basic definition but add "expectations accepted by the society of which the individual is a member".

structures is discussed in the third category, after which the stigma regarding mental illness is situated within their socio-cultural context.

THEME	CATEGORY	SUB-CATEGORIES
4.2.4 Socio-cultural context	4.2.4.1 The nature of participants' culture	4.2.4.1.1 Subcultures exist within the Sesotho culture 4.2.4.1.2 Our culture is changing
	4.2.4.2 Being Sesotho is associated with certain customs.	
	4.2.4.3 Culture influences important social structures.	4.2.4.3.1 Females are regarded as subordinate to men. 4.2.4.3.2 The elders dictate and support – on their own terms
	4.2.4.4 Stigma exists regarding mental health conditions	

4.2.4.1 The nature of participants' culture

Participants explained two important aspects about the nature of their culture, which are handled as two sub-categories: the first touching on how different

subcultures exist within one Sesotho culture; and the fact that their culture is currently in a process of change.

4.2.4.1.1 Subcultures exist within the Sesotho culture - "we are Basotho's but we are different".

> ***Tsego:*** *In our culture, we are different. Each and every culture is having its own roots, and then we differ… even if we are the Sotho's, we are different in the way we deal with our things. There are Basotho's who are coming from Lesotho, who are more more more – deep in the roots… (...)Yes, the real ones. And then there are the Sesotho's who are here in the Free State, who are the Sotho's also, but they are not doing the same things that are happening in Lesotho. Yes. So we are differ – they way we are doing things, the way we enter the marriages …the way we…we…we…we… make our children follow the culture is differ – really it's differ. We are not doing the same thing. We are one Basotho's ... we are Basotho's but we are different.*

What Tsego described here, is almost exactly like the definition of subcultures as provided by Ferraro (2001:23): "subcultures are subsets of the wider culture". Any subculture is directly related to the mainstream culture (in this case the Sesotho culture), with certain alternative interpretations of the customs of that culture (Ferraro 2001:23).

When learning that the Sesotho person may associate with subcultures not even remotely discussed in this study, it almost left me disheartened about the value of

this study. However, Masabatha's remark reminded me of the value of client-centred care in occupational therapy:

> ***Masabatha:*** *What is really important, is that everybody's needs are individual and different, not necessarily because of culture.*

If the above reminder could be taken to heart in daily practice, culturally responsive therapy[17] can be the result – no matter what subculture is relevant to the patient.

4.2.4.1.2 Our culture is changing – "we do not know what to do"

Lerato, Olivia, Jennifer and Tsego described how their culture was changing. They were able to identify certain causes for these changes; and if these factors were not causes, they were at least to them clear indicators of a changing culture.

> ***Lerato:*** *The homelands! We were well organized in our homelands. So now, this new South Africa, it opens to everybody. So this one will move from here, to that place. You know, we are all mixed together now. So I had to change from my own….eh eh eh eh…(tsk)…..culture, to Basotho. Because we stay with Basotho in Thaba Nchu. Now we copy all this…eh….different cultures of other tribes, and then we mix them with ours, so the trouble is we don't know what to do. (...)…it's a mixed feeling of the cultures. We don't know what to do anymore.*

[17] Culturally responsive therapy is 'treatment that hold cultural meaning for clients'. (Muñoz 2007:270)

Lerato ascribed the change in her culture (Greenfield 2009:401) to the fact that she physically moved to Thaba Nchu, where she had to or chose to adopt their ways of doing things. The underlying factor here, may be some variation of urbanization (Ferraro 2001:370). Urbanization is the moving of people from rural areas to more urban areas, places such as Thaba Nchu. Thaba Nchu is within a daily commuting distance from Bloemfontein, which has greater employment opportunities than rural areas. What stands out from Lerato's quote, is the emotional impact of a changing culture on its people:"we don't know what to do".

> ***Olivia:*** *Yeah – I was saying that the difference now to the old days is the change in religion. Because we are still black, and Sesotho. But you'll find that the religion that I believe in doesn't allow me to do certain things from my culture…So, the…the…the…the…..the religions that are there now, are changing us….are taking us from our culture. Because then if you go to some church, they tell you that's not your mother…that's an evil spirit. Meaning your mom's grave. So difference is made by the religion.*
>
> ***Tsego:*** *So that's why, she's saying, Olivia, also the religion. You go to the different religion, and they tell you, don't believe in ancestors. Don't go and pray to them.*

Olivia identified one difference in her culture: "the change in religion". During the focus group, this was one of two chances she took to share her opinion at all, and she appeared very passionate about it. No doubt this situation was quite tough to her, since she was basically expected to choose between her culture (which requires her to pray to her ancestors) and her Christian religion (which do not support praying to one's ancestors). It seemed to me as if she almost felt threatened or at least disheartened by the situation. Confirming something of what Olivia is

experiencing, Ferraro (2001:302) points out that, should a person take his religion seriously and feels passionately about it, it may also be that he sees his own religion as 'superior' to other 'inferior' religions. It looks as though Olivia is now experiencing this predicament of having to decide whether her religion or culture is going to become subservient.

> ***Tsego:*** *White people, Chinese, Indians, they don't change their culture. They are still on their culture. They are still following whatever…even if they are in South Africa they are still following their culture, they are still wearing their clothes, they are still doing whatever. I know, the Africans, the Afrikaners or whatever…they are changing their clothes, but they are still following their culture. But why us blacks, we change our culture…because of the religions, you see. And the religions change us a lot, because I go to this church where they say you must not slaughter, and not make some feast… And then I know when I was growing up, my grandfather, my father…they were slaughtering a goat, and then we would bring this feast, we were doing a sorghum beer, and at home we would make some 'motogo', we'll do what….and even make some spinach or some dumplings, there's no rice but the dumplings will be there. Why I have to change?*

What Tsego described above (in addition to the other accounts of a changing culture) may be a mixture of 'diffusion' and 'acculturation'. These two anthropological terms are difficult to distinguish and dissection thereof is not within the scope of this study. However, I will define them in short; in an attempt to

understand more of the frustration - “Why I have to change?” - the participants are reporting.

Diffusion refers to the changing of a culture through the “spreading” from one culture to another (Ferraro 2001:350). In this study, Lerato’s report of moving to Thaba Nchu, and taking on some of their customs, may be an example of diffusion.

Acculturation is described by Ferraro (2001:352) as “a special type of diffusion that takes place as a result of sustained contact between two societies, one of which is **subordinate** to the other”. Olivia and Tsego could possibly regard the fact that they are prohibited by their churches to pray to their ancestors, as a process of acculturation. The idea of Olivia and Tsego being prohibited by their churches to pray to their ancestors, resonates well with the definition of acculturation, especially since there seem to be a taste of ‘ordinance’ or ‘instruction’ to the situation.

> ***Jennifer:*** *Yes, even the insurance has made a difference to our culture. Because in the past, eh….a corpse was meant to be buried in three days, to avoid any unnecessary expenses. But, of late, since eh…eh…eh…we apply for the insurance, the insurance will release the funds after five or seven days. We have to wait for it….*
>
> ***Tsego:*** *And sometimes they are doing post-mortems and what what…they are still investigating. Before they give you money. So those things, all of them…they make the corpse to wait for maybe two weeks or what, before we can bury him.*

As will be discussed in 4.2.4.2, Sesotho people have certain customs when burying the dead. These customs include that a person should be buried within three days. However, with modernization also affecting economic development and financial

ways of doing (Ferraro 2001:364), many people are today buying funeral policies which ultimately also impacts on their culture. These policies would pay out an amount of cash to finance a person's funeral. However, rules and regulations include certain requirements such as post-mortem examinations, which then delay the paying out of the funds. This leads to burials happening much later than required by the Basotho culture.

According to Ferraro (2001:31), anthropologists are not clear on the exact causes of culture changes. They do agree, however, that factors internal and external to the cultural group could play a role. Factors that are mentioned by Ferraro (2001:31) include economic and social circumstances, which certainly also includes the ones mentioned above: urbanization; taking on non-traditional religions and economic development.

To describe the nature of the culture of participants would certainly be a mammoth task and clearly falls outside the scope of this study. However, these two subcategories (that indicated that their culture includes subcultures, and that their culture is changing), may prove to be invaluable information when considered together with the other findings of this study.

4.2.4.2 Being Sesotho is associated with certain customs.

Ferraro (2001:22) defines culture as "everything that people *have, think* and *do* as members of a society". The customs mentioned by the participants refer much to what they 'think' and 'do'; specifically with regards to mourning and burying the dead. These customs were mentioned spontaneously in the focus group interview, in an attempt to answer the primary question under discussion: 'What do I need to know about your culture?'

The first custom that was described, involved specific rituals following a person's death; specifically with regards to the burial of the deceased and then the mourning. During this description by Lerato and William, the confusion caused by a changing culture was mentioned yet again (cf. 4.2.4.1.2).

> ***Lerato:*** *…they do it differently. The others do it differently. Others will say, we are going to slaughter in the yard, and pour some blood. Others will say, no, we'll buy a sheep…no, not the sheep, the meat from the butchery. So they they they they…it's a mixed feeling of the cultures. We don't know what to do anymore. Our…our…our…our… in-laws, they don't know what to do. They are confused…they wanted to…they are Tswanas but they wanted to live like Basotho's.*
>
> ***William:*** *Ja, let's say somebody has died. Because now the things has changed, nê, so that…now what I'm seeing…some of the people they are slaughtering on the Thursdays, and then after that they take the meat to the butcher and slice the meat on Thursday. But now, in our culture, we are supposed to slaughter Friday, when the….*
>
> ***Lerato:*** *The corpse…*
>
> ***William:*** *When the corpse comes home. Ja. We are slaughtering by that home. So we are not slaughtering on Thursdays or Wednesdays. Everything will be done on the Friday, and the meat is not supposed to be cut by the butcher. The men will be there and they will try to slice the meat with their knives…*

> ***Lerato:*** *So that is why some of the Basotho's even today, they slaughter early in the morning, and then the meat will be fresh, and the skin will be fresh and then somebody will just be wrapped in the skin. They don't even dig a hole, they don't even do that. I don't know how they do it, but somebody will be sitting in the grave, you know….*
>
> ***William:*** *Wrapped in the skin.*
>
> ***Jennifer:*** *He was meant to sit* ***(in the grave)****, wrapped with the skin. And always, he will be made to hold some seeds like maize, sorghum, beans. And – uhm – with the intention that wherever he was going in…he will sort of increase production. Those things will die gradually.*

Sesanti (2010:350) reminds us that the dead, the deceased, are still part of the African person's community. When we look at the quotes above, the dead is probably then also still part of the community of the Sesotho speaking person. Tyrrell and Jurgens (1983:179) describe how two characteristics of death require those left behind to perform certain rituals. Firstly, the deceased is entering, or being born into, the ancestral world; and needs to be respected as such. Secondly, death brings along a "form of ritual impurity"; contaminating the environment and all surrounding the dead (Letsosa & Semenya 2011:2). With this background of why these rituals are required from the Basotho, I will now summarize how the participants described the steps to be taken upon the death of a loved one.

The deceased is supposed to be buried on a Saturday. This leaves the family to slaughter an animal/s on the Friday. Traditionally, they are required to do so by themselves, at home; but nowadays, especially when living in an urban area,

butchers are employed to do the slaughtering. The deceased may be wrapped in the skin of the slaughtered animal, and buried in a sitting position. The person may also be buried with several kinds of grain in his hands; with the expectation that he would return to "increase production" for his relatives. These rituals are confirmed by Tyrrell and Jurgens (1983:182-183) to be customary for many black citizens of South Africa, including the Basotho.

Letsosa and Semenya (2011:1-7) write about mourning and bereavement according to the traditions of the Basotho, and state that there are more than one stage of mourning involved. During the first stage, the bereaved are expected to refrain from certain duties and activities, including the attendance of church and other funerals (Letsosa & Semenya 2011:2). Following this stage, the bereaved have to go through "*Go tlošasetšhila",* a form of traditional purification performed by a traditional doctor.

Although the participants did not explicitly reported this traditional purification, they did mention how a women, would be expected to mourn the death of her husband by following certain rules. Failure to follow these rules as explained below, might lead to "bad luck" which could only be cured by a traditional doctor.

Firstly, for three months to one year, she would have to wear black clothes, perhaps even the same sets of clothes until torn. She would also be expected to be at home before dusk, and refrain from any relationships with other men; as participants in the focus group explains below. (Once again, it is noticeable how the modern day way of doing is impacting negatively on the Basotho customs).

> ***Jennifer:*** *I think these days it's a bit difficult because of the level of the education that we are having. Because of the*

positions that people have, especially at work. Because you can't be a nurse and go to work, all wearing black. So I think for now, it's a bit of a challenge, to mourn. Especially, with us Basotho, I need to wear that black thing, and I am not supposed to come home late at night, after dawn (meaning dusk???) but I'll go home at eight or nine o' clock, after I knock off at work, and it is already late. And I'm still having that thing where I am not supposed to get in the house after dawn (meaning dusk?) So it's a bit of a challenge.

Tsego: *It makes you feel bad, because of the bad luck. Because you can't come home after dawn, if you are mourning. And if you negotiate with your supervisor, he doesn't understand, because it is your culture. When I am mourning, even if you are not wearing the black clothes or whatever, but I am mourning, I must be at home before dawn…it must be like that. Like now, I know some of the nurses, they are having white mourning, but they must…they know, it is five o'clock…I must knock off…but she works until seven o'clock…but she is mourning, she must be five o'clock knock off…(trailing off)*

Mia: *Who depends the mourning time?*

More than one group member: The elders.

Jennifer: *Those who are not working. The elders they do not work.*

Tsego: *They can say six months, they can say three months. They can say a year (claps her hands once).*

Jennifer: *In the past if a woman had to mourn for her husband – they would mourn for a year wearing black attire. With a blanket. A Charlie, and something on the head. But then we are trying really to get rid of that because really – it is hectic.*

Tsego: (interrupts) *But even it's torn. They will wear it...until it's finished on you. And then you don't wash it in the afternoon. And then you won't wash it in the afternoon. You will wash it at night, in the evening. And you have to rely on….putting it outside, then dawn, you wear it. You must not do a mistake. You don't even come near a man...*

Mia: *What would happen then?*

More than one group member: *Loud laughing and talking – inaudible.*

Moreng: *They say that if you don't mourn for that particular period. That man…or maybe take myself. Maybe my wife don't mourn for me, and then it happened…maybe before my – they used to say in my language (speaks Sesotho…….) Before your gallbladder is cut off, then something will happen to your partner. She may fall ill.*

Lerato: *It is true that – if you don't mourn something will come to you. I remember I saw grown-ups. The wife passed away and the husband was having an affair somewhere. You know, people were talking and they got this bad rash…all over the body. They had to go to Lesotho for cleansing. So it is true that if you don't abide…*

> ***Tsego:*** *The gall must be burst. The gallbladder, in the ground, where he is laying…*
>
> ***Lerato:*** *…in the grave…*
>
> ***Tsego:*** *…even in two years, you can have some partner, after that. But before that, before that gall burst, you don't have to be intimacy between you the partner. You, you, both of you…you will get the rash all over. And then you must be healed by someone who can wash both of you…wash you.*

In closing about the mourning process: "The purpose of mourning to the Basotho is to express sorrow" (Letsosa & Semenya 2011:2). This is seen in a positive light, in that it expressly allows a person to experience his/her grief, a process which may promote emotional healing (Hume 2008:383-392).

A last custom mentioned by the participants, is that of 'making feast', as Simon described below.

> ***Simon:*** *Our culture is too difficult too take into account at The Clinic. For example, if I dream about my ancestor, I must slaughter a sheep and make home-brew and cook bread. But I will wait until I am discharged. It is good to dream about your ancestors, because it means they are protecting you.*

Simon provided this answer in response to Question 22 in the biographical questionnaire – on how his culture could be taken into account at The Clinic. This account, once again, reminds one of acculturation...Simon cannot perform his

cultural customs at The Clinic, where another culture (which do not condone 'feast making') prevails.

4.2.4.3 Culture influences important social structures.

Two aspects regarding social functioning have been discussed so far. Firstly, that of experiencing family members as a source of stress and support (c.f. 4.2.1.5.1). Likewise, it seems the participants holds family involvement as a value (c.f. 4.2.2.2). I will now look at two social customs which has not been explained earlier in this chapter, but certainly also play an important role in the social participation of participants.

4.2.4.3.1 Females are regarded as subordinate[18] to men.

The whole of the South African society is still regarded as broadly patriarchal (Pretorius 2005:372). It was therefore not suprising to hear reports of similar nature from the Sesotho participants. These reports were made by female participants, and supported by some male participants.

> ***Mia:*** *Does culture have any influence on your work?*
>
> ***Olivia:*** *Ja. For me it has. Because where I am working I am supervisor of treasury at (a bank). And I've got four sub-ordinates, two are male. And the two males, they take it very hard to accept…uhm…what is this…instructions from me. They will tell you….speaks Sesotho…meaning you are feminine, you can't say.*

[18]Subordinate: of inferior importance.

Jennifer: *Ja, it does…because like men…they want to make strategies, policies and so forth and so on…when you come up with a strategy…uhhh, really, it will take time for them to accept it can work. (...)These days, we have to work, we have to plan together. And unfortunately, that is a big problem, because that respect is no more there. In the past it had to be there, because the father had to provide everything. But, of late, you find that women occupy better professions than men, and in most cases when it comes to financial deliberations, women would have more income than men…in a way it makes men feel like they are all but nothing. Or they don't have the power they used to. So that really creates a problem. Hence why you find that in most case, some of us are here because of the interactions, that males would say you think you are better…*

Tsego: *You must not be over them* ***(referring to men)*** *– you must maybe be under them.*

Agreement indicated by more than one member, including males: Eeeh….yes….you must….

William: *You know by that time you know the women they were the one who were under…even if you are more qualified than me, it was supposed to be like that.*

These reports are in line with what is described as male dominance, justified by gender ideology (Ferraro 2005:247). What seems to be most distressing to female

participants about having to be 'subordinate to men', is that fact that it leads to role conflict and tension at work and in marriages.

When talking to a patient reporting oppression by any person (male or female), my first instinct as therapist would be to lean towards training in assertive communication. However, considering the customs of the Basotho, as reported by this sample, it may need to be reconsidered.

4.2.4.3.2 The elders dictate and support – on their own terms

The elders, as reported by the participants, seem to be older people of great influence. They dictate and support the younger people (usually in their extended families), on their own terms.

> ***Mia:*** *Who are the elders?*
>
> ***Tsego:*** *Our parents, our grandparents, our parents' parents… (and should they pass away) The uncles… even the in-laws are your elders. If you are not married the uncles and aunts they are your elders.*
>
> ***Tsego:*** *(The elders) dictate our movement*
>
> ***Jennifer:*** *How we have to behave ourselves or how we have to move, how we have to run our families. Like…eeeh….me being a woman, I'm not supposed to be out of the house until 19:00 in the evening. The latest I have to be in the house is by five. (If I have to work later) That I have to discuss with my elders. State the reasons why I'll be at home during that time. Otherwise if I don't do that it means I'm associating with*

men, somehow… (and if you do not obey) Whatever you may come across will really be your own problem. You won't get the support.

Tshiamo: *If there is an 'argument' in group therapy (role play?) the therapist need to respect that younger people should respect the elders. 'I am 29, I cannot argue with a man who is 40'.*

What is described above, include the supportive and mitigating roles of elders. Another angle to these roles, is that of taking responsibility for their community (Turnbull 2010:238) and regulating the community (Sesanti 2010:350). The characteristics of elders as described by Turnbull (2010:238) and Sesanti (2010:350), is in line with the descriptions provided by Jennifer, Tsego and Tshiamo.

4.2.4.4 Stigma exists regarding mental health conditions

Participants reported opinions and scenarios regarding their admission to mental health facilities (Both Clinics), that could only be regarded as a case of stigma[19]: the idea of the public about mental illness, as well as participants' own illiteracy regarding mental illness. Gilbert, Selikow and Walker (1996:49) identified five cultural aspects of health. These aspects are listed below, and are present in the stigma as described in the population.

The nature and cause of the disease

The ability to recognize symptoms as abnormal

[19] Some synonyms for 'stigma' include dishonor; shame; disgrace and stain. In the present study, stigma would refer to the 'dishonor, shame, disgrace and stain of suffering with affected mental health'.

The ability to react in response to the symptoms

The ability to seek help

The reaction to treatment (i.e. feedback regarding effect of treatment to be considered within the patient's socio-cultural context)

The first, most prevalent scenario, is that of poor insight in their own mental illness; the inability to recognize symptoms as abnormal and seeking appropriate help:

> ***Moreng:*** *Eish…crazy and depressed*

> ***Olivia:*** *(I thought I...)...was going mad.*

> ***Tsego:*** *The bad thing is that I was looking really bad. And me also – I thought I was mad.*

Lerato then brings in the subject of their communities' idea about their mental status prior to admission to either Clinic:

> *I just want to say, maybe it's out…but with with us…eh, at home, for the people…we don't have the stress. It's madness…*

Stigma regarding mental illness, is responsible for ongoing and persistent suffering of people suffering from mental illness. This suffering is the result of a holistically affected life: relationships, productive occupations and every other aspect of life is affected by stigma, and outsider's (including friends and family) reaction to the patient (Kakuma, Kleintjes, Lund, Drew, Green and Flisher 2010:116-117).

> ***Mia:*** *Now being in this hospital, suffering with depression…what do your elders say about that? Do they have a say?*
>
> ***Jennifer:*** *They don't really care*
>
> ***Tsego:*** *They don't take much care. They don't even want to hear.*
>
> ***Jennifer:*** *Jaaaa….it depends on the type of support that you give to the family. If really there is something they benefit much from you, that is when they will show you the support. But if they feel that no…they are not benefitting…no, at times they will call and say 'get well' and in some instances they will just leave you like that until you are healed or you die. That's the way…*

In this scenario above, the elders' reaction is most prominent in causing the participants distress whilst they are already suffering considerable emotional distress.

Another aspect of stigma and poor insight in mental illness, is that it affects help-seeking behaviour. Jakes provided a good example of the effect of a combination of stigma and possibly culture, on his own treatment:

> *I feel I do not need anti-depressants, because my parents and grand-parents did not need to use it.*

Help-seeking behaviour, and the preference of treatment modalities are influenced by knowledge about mental illness. At the same time, stigma thrives on misinformation (Hugo, Boshoff, Traut, Zungu-Dirwayi & Stein 2003:715). Petersen and Lund (2011:751) state that improved levels of literacy on mental health issues, can lead to improved ways of help-seeking behaviour and stigma being reduced.

Moving towards a conclusion on the socio-cultural context of the participants, one final aspect will be considered. Questions 21 and 22 in the biographical questionnaire, provided participants with the platform to comment on how their socio-cultural context could be considered in the group therapy program at The Clinic.

Participants made the following recommendations, which will be put down without any comment by myself or literature control. These recommendations will be considered for inclusion in the recommendations made in Chapter 5.

> ***Daisy:*** *'Some therapists are Believers, but not in ancestors. They say you should pray, but how?'*

> ***Thabo:*** *How about praying together instead of just talking about religion?*

> ***Thabo:*** *Maybe all the patients do not understand English as well as you think.*

> ***Thabo:*** *How about praying together instead of just talking about religion?*

> ***Masabatha:*** *Poor education need to be taken into account.*

> ***Mphohadi:*** *Even though you still speak English, use a Sesotho approach. Greet in all the languages. By so-doing you are making everybody feel more comfortable.*

4.2.5 Summary of findings

Congruous with the methodology of the study, and the reports of findings so far, the Kawa Model is used to summarize the findings. Mphohadi, a 36 year old male police official, gave an ingenious description of the metaphoric life as a river.

> *A river…its water can run, can stand, can be still, can be shallow, can be deep…it can have those rapids…those waterfalls. It's got so many things. And within the river, we find many things. That you can eat, that you cannot eat, that are dangerous, that are not dangerous, that are friendly, that are not friendly.*

Within the river of the Sesotho speaking population involved in the current study, we certainly found "many things"! Figure 4.2 below, attempts to portray the river of participants' lives, including these 'many things'. These aspects will now be

discussed with a view towards reaching conclusions, allowing me to make recommendations with regards to culturally relevant therapy (cf. Chapter 5).

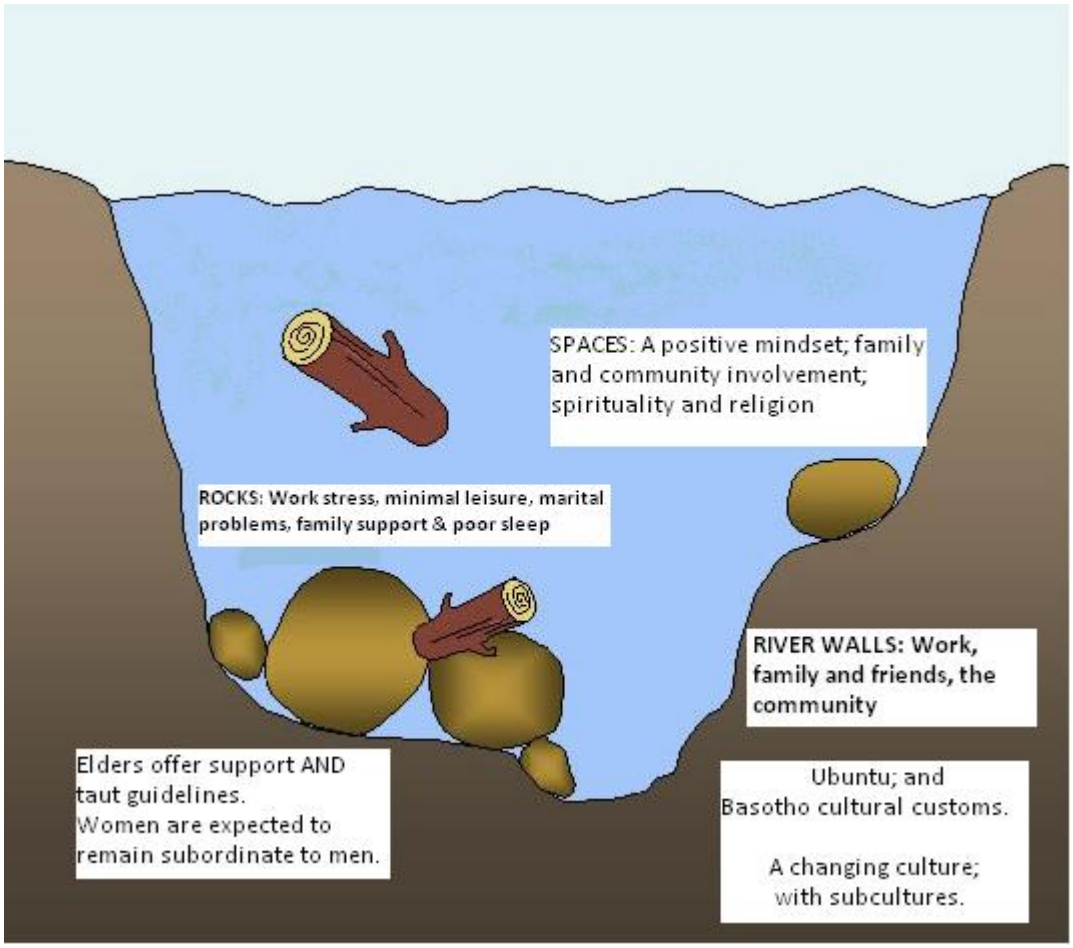


Figure 4.2 - A cross-section of the river of participants in the present study.

Quite a few participants described their rivers to be dry, or with the water standing still. Another portion of the sample described their rivers as stormy, and in flood – with rocks upsetting the flow, causing rapids in the stream.

Whichever way described, with the river being dry or in flood, all participants interpreted the flow of their rivers to be less than ideal. Only two participants had any ideas on how to improve the flow of water, and both by stating that their leisure

activities and/or community participation allow improved 'flow' of water; and therefore improved flow in life.

With regards to the **'river walls'**, the support systems, a golden thread is visible: family, friends and colleagues are regarded as important sources of support. It is, however, interesting to note that these same support systems also appear in the same rivers as rocks, pointing to problematic relationships and many responsibilities. A strong sense of an interconnection was observed in participants with their families and communities; an aspect of needing each other and living through each other. This was coined as *ubuntu,* an important characteristic of the socio-cultural context of the Sesotho speaking person. *Ubuntu* refers to a collective worldview and philosophy which includes aspects such as caring for one's extended family, even when it proves to be very difficult, or restricting the flow of water/life by providing a narrower space for water to flow through. Other socio-cultural factors that impacted on the Sesotho speaker, as parts of his river walls and bottom, included their culture. The Basotho culture was reported to include certain customs, especially regarding the mourning process. In the description of their cultural customs, participants made it clear that subcultures existed within their culture; and these 'different' ways of doing often had to do with the burial and mourning of the deceased. At the same time, the participants described uncertainty regarding the walls of their rivers: since they experienced their culture to be changing in the face of urbanization, and the processes of acculturation and diffusion. The involvement of elders (older people such as parents, aunts and uncles) was described as a characteristic in the social structure of Sesotho speaking people, which may offer support, or conversely, restrict the flow of water/life by providing taut guidelines. Another characteristic which emerged as a confining characteristic in the river walls of specifically the female participants, was that of women being expected to remain subordinate to men.

With regards to the **'rocks'** in the river, or the problematic factors preventing optimal flow of water/life, a wide range has been reported. A rock mentioned by the majority of participants, is that of 'work' and job related stress. The most distressing stressors at work, revolved around interpersonal conflict and unfair treatment. Literature (Mazzola *et al.* 2011:93&97) was cited to indicate that these stressors are experienced globally, and are therefore not limited to the sample in the present study. At the same time, it is globally accepted that work stress may cause mental health problems, which in turn may affect the person's other occupations (i.e. sleep, leisure, social participation). This rock called 'work' is therefore a significant factor that prevents life to flow optimally.

Another rock mentioned often, is the immense burden of financially taking care of many family members; which I might have regarded as self-imposed, if not viewed within the context of *ubuntu.* It is important to note that, since interconnectedness is a value and a way of life to participants, this rock of 'caring for the family' is not a rock one should try to 'remove' during OT intervention. Rather, as intervention is planned within the framework of the Kawa Model, the aim would be to optimize the flow of water by pushing certain rocks out of the way in order to make the spaces larger. These spaces may refer to other occupations, or improved life skills.

A lack of good quality sleep was mentioned by more than half of the sample as a rock in their rivers. It seemed that this rock, expected in this population suffering with Major Depressive disorder, can be at least partially eroded by an improved knowledge of good sleeping hygiene. The participants, for example, reported they would vigorously clean their homes before bedtime. If they could learn that this habit may impact negatively on the quality of their sleep, they may see this rock shrinking in the face a stronger flow of life – enabled by beneficial habits.

Some participants regarded insufficient 'free time' and time to participate in hobbies, as rocks. However, they were able to mention a range of leisure activities they regularly partook in (i.e. watching TV, listening to music, socializing, cleaning their homes, garages or yards). What was striking in this category, or rock; was how different the participants' perception of leisure was to the traditional, Western idea. An example of this perception, is the fact that some participants regard domestic cleaning as a leisure activity. (This pointed to a rock in the river of occupational therapy – our rigid perception of leisure equalling hobbies and time-off, seems inappropriate in this population!)

Furthermore, it seemed that a range of marital problems were responsible for blocking the rivers of participants. Marriage, as a social contract, is expected to be part of a person's social support system. A person may therefore choose to plot his marital problems as rocks, restricting the flow of water; or as a river wall not providing enough space for the flow of water.

It was refreshingly easy to identify the **'spaces'** in participants' rivers – the spaces through which water could flow with ease. These were coined as values, in Chapter 4, but the quotes taken from participants' responses, linked well with the idea of spaces for water to flow through. The first space was the value of having a positive mindset. Although the risk of employing repressive coping styles, masked as optimism, exists; the positive side was that optimism proved to be a strong coping resource. Ultimately, coping is what keeps a person's river flowing; and it is therefore regarded as a large and important space in participants' rivers.

The second and third spaces are provided by involvement in family and community. So, even though family and community (i.e. colleagues) may have been mentioned

as rocks and/or restrictive river walls; it ultimately also provided a participants' with the opportunity to experience life to its fullest extent. The words of Masabatha echo over this river –"That gives me life!" (cf. 4.2.2.3).

A final, very valuable space, is the value of spirituality and religion. Participants reported how prayer, and a God they perceived as caring, provided them with abundant support and comfort. At the same time, however, they reported this space to be in danger of shrinking – with the cultural changes described earlier (cf. 4.2.4.1.2) to be part of a shaky river wall.

The aim of occupational therapy is to use the 'spaces' to allow ultimate flow of water/life. This, in turn, may erode or move some 'rocks' and shape the 'river walls', in order to allow a better flow of life. In the lives of the participants, the aim would also be to enable them to use their available resources and skills to cope with the problems they face. At the same time, spaces may be created by learning new skills, gaining more self-knowledge and self-confidence, or even just understanding their 'disorder' better. Recommendations regarding the aim and application of occupational therapy, are made in Chapter 5, after reflection on these findings and conclusions.

4.3 CONCLUSION

Chapter 4 dealt with what data revealed on the occupations and socio-cultural context of Sesotho speaking adults with mental health problems, admitted to either of the Clinics. Information on the occupations of the participants indicated that an alternative conceptualization of occupation may be due, especially when taken into account that the most prominent of conceptualizations, originated from the West. Conceptualizations from the West are known to contain principles such as autonomy and independence as goals; while Eastern frames of reference are more focused on

interdependence and social connections. Findings revealed the philosophy of *ubuntu/botho* in participants, relating to a life of interconnectedness. This is a philosophy and worldview reconcilable with the East, rather than the West. It was therefore not surprising that the Kawa Model (from the East) proved to be efficient in gaining the narrative from participants. Information on the socio-cultural context of participants indicated some trends and some traditions...with similar power in causing participants comfort and even discomfort in daily living. Finally, some stray comments are jotted down, which will be incorporated into the recommendation in Chapter 5.

Chapter 5 provides a conclusion on findings, from which recommendations for therapy and research are made. Limitations of the study are also discussed.

Chapter 5

Conclusions and Recommendations

5.1 INTRODUCTION

In the previous chapter, the findings relating to this study were presented, discussed and interpreted along with relevant literature. Findings described the participation of the Sesotho speaking adult with mental health problems, in occupations; within his/her socio-cultural context.

This chapter will bring the study to a conclusion, referring to the findings which were presented and discussed in Chapter 4. Recommendations are made, with a view towards providing culturally relevant practice to the Sesotho speaking person with mental health problems. Recommendations for further research and training are made according to all the aspects discussed. Following the recommendations, the limitations of the present study are discussed, and finally, the dissertation is closed in 5.7.

5.2 CONCLUSIONS

Conclusions are grouped in two clusters: the conclusions relating to the aim of the study; and then the conclusions regarding the use of the Kawa model in the present study.

Conclusions regarding the aim of the study

The aim of the present study was stated in Chapter 1 as follows:

To explore the occupations and socio-cultural context of Sesotho speaking adults admitted to The Clinics with mental health problems.

The findings as explained in detail in Chapter 4, are now summarized in line with the aim of the study.

5.2.1.1 Occupations:

Findings on occupations as a whole, highlighted the need for a conceptualization of occupations and occupational balance, different to the traditional categorization of 'work, leisure, sleep, personal management and social participation'. The subjective characteristics of occupations (restoration; productivity and pleasure) as identified by Pierce (2003:45) proved to be more suitable, when used to interpret the occupations of the population in the present study. The traditional notion of 'balanced participation in occupations' being '12 hours for sleep and leisure, and 12 hours for work and personal responsibilities' may also not be sufficient in the present population (Jonsson 2008:3-8), and again, Pierce's (2003) notion of 'restoration, productivity and pleasure' seemed to be more appropriate to describe balanced participation in occupations. Based on the previous statements, it needs to be added that the form of occupation (i.e. work) cannot exactly predict the experience an individual would have thereof. For example, work has the ability to impact positively and/or negatively on a person's health, according to the individual's experience thereof.

(*Even after explaining the need for a different conceptualization of occupation; for ease of reading and in an attempt to remain consistent with Chapter 4, I will continue with the traditional divisions of occupations as work, sleep, leisure, personal management and social participation. Following this, the findings on occupations,*

will be discussed according to 'productivity, restoration and pleasure' as coined by Pierce.)

5.2.1.1.1 Work

Participants reported high levels of work stress, often related to interpersonal conflict, which may occur due to factors beyond the control of the individual. Participants reported how not coping with work stress, could impact negatively on their mental health. In spite of reporting several stressors at work, participants also reported their working places as part of an important social structure, including valuable sources of social support.

5.2.1.1.2 Sleep

Insufficient sleep is associated with depression, either as a causing factor or a symptom. Participants reported poor sleep, partied with poor sleeping hygiene. They indicated sleeping medication as their only method of treating poor sleep.

5.2.1.1.3 Leisure

Participants reported a wide range of leisure activities, including cleaning their homes. As stated in 5.2.1.1 above, a different conceptualization of occupation may be required. This was highlighted by the way participants regarded seemingly non-traditional leisure activities (i.e. cleaning their homes), as leisure.

5.2.1.1.4 Personal management

Reports of poor skill in financial management, have been made. 'Going overboard with helping', as described by Tsego, is associated with *ubuntu. Ubuntu* has been identified as a prevalent philosophy amongst participants. It entails, for example, financial assistance to family members, possibly even beyond their own financial means.

5.2.1.1.5 Social participation

Problems in social participation were described as issues revolving around spouses, extended family and colleagues. Family was regarded as an important source of support, albeit simultaneously a great source of responsibilities and stress. Participants reported how they would still financially take care of family members in their extended family. This responsibility linked to *ubuntu:* community first! Several participants reported to be in troubled marriages; a state they ascribed to either poor communication or involvement by third parties. With regards to poor communication skills, they highlighted assertive communication and conflict management as the greatest areas of lacking.

5.2.1.1.6 Occupations in terms of Productivity, Restoration and Pleasure.

As written in 4.2.3.1, Pierce's three subjective characteristics of occupations, occur in a variable blend. Pierce's theory has not been used in the planning or conduction of the study, and it would therefore be impossible to summarize participant's experiences of these characteristics, but I will none the less report what participants collectively reported on their experiences of occupations.

Pleasure is found in occupations not regarded by traditional occupational therapy literature to be pleasurable. The most prominent example would be participants' reports of cleaning their homes as a pleasurable pastime. With sleep being one of the most important restorative occupations, the participants with great sleeping problems are missing out on the opportunity to be restored by sufficient sleep. Other occupations described in a way which resembles 'restoration' included social contact with friends and family. Productive activities include those done for its outcome; activities that are goal driven. The characteristic of 'productivity' has been

observed in participants reporting their community involvement with great emphasis on the contribution they make to society in partaking in these activities.

5.2.1.2 Socio-cultural context:

What was seen very clearly in this study: socio-cultural context is an utterly complex construct with vast possibilities for exploration and understandings. However, within the scope of this study, both occupation and socio-cultural context are reciprocal to each other i.e. occupation within socio-cultural context, but the latter also remaining within the context of the understanding of occupation.

The socio-cultural context of the Sesotho speaking adults partaking in this study, proved to be a surprising collection of customs and ways-of-doing; a mix of traditions and trends. The first category emerging from the focus group, is that of the 'nature' of the Sesotho person's culture. This category confirmed that subcultures exist within the Basotho culture and serve as a reminder, a warning against assumptions of generalization, as echoed by Lim (2009:85).

> *Whatever information I think I have on the culture of a patient, it has to be verified with the client, who can then supplement if necessary.*

Therefore, even if I meet a Sesotho patient, I cannot assume I 'know' his culture. Rather, I may need to ask the patient about aspects I think necessary for planned therapy.

If sub-cultures within the Sesotho culture will not provide enough confusion, their changing culture may do so. Participants reported their culture to be subjected to rapid social changes. According to several of the participants, these changes affect

Sesotho people in different practical ways. For example, arranging a funeral for a deceased loved one, may prove difficult to keep within the cultural boundaries, if you have to wait for insurance to pay out the money necessary to fund the funeral.

The Sesotho participants reported their social contacts to be extremely important and valuable. This is in line with *ubuntu/botho* which seems to be relevant to most members of the study sample. In spite of the ideal of interconnectedness, female participants experienced incidences, and possibly a culture, of gender inequality at work. Along the same lines, elders were described as dictators, who support on their own terms but would be quick to take on a mitigating role in case of conflict.

5.2.2 Conclusions regarding the use of the Kawa Model in the present study

No literature on the use of the Kawa Model in a South African population, could be found in the literature searches (Appendix A) for the present study. I will now list my own impressions of the value of the Kawa Model in the Sesotho speaking population involved in the present study.

- Most participants related very well to the metaphor of 'life as a river' and found it possible to explain their lives as rivers. (In fact, what initially lead me to choosing the Kawa Model as conceptual model for use in this study, was a Sesotho patient at The Clinic, stating that 'Life is like a river'...)
- The use of the model provided participants the opportunity to voice their narratives. It provided me with the opportunity to ask for more detailed descriptions, without working in a deductive way.
- Even so, the way I used the model during the interview to prompt participants to answer my questions about occupations as I have been schooled in (work, sleep, leisure, social participation and personal management); may have been

deductive and not a good fit with the initial idea behind the Kawa Model as a non-linear, non-traditional model. If used without prompts in specific directions (i.e. work, sleep etc.), a different conceptualization of occupations may have been discovered.

- The three-dimensional model of a river proved to be an efficient piece of back-up, should a participant struggle to describe their lives as rivers. This model consisted of a painted milk box with two sides cut open and the silver insides, representing the river-walls; and several rocks were available, as were pieces of driftwood.

- The Kawa Model allowed participants to be shaped by their social contexts (his/her river walls). The river walls are then also influenced by the life of the participant (the flowing water). The interconnectedness or *ubuntu* expressed by quite a few participants, can therefore be expressed within the Kawa model.

Urbanowski (2005:302) describes the strength of a model:

> *The effective strength of a model lies in its ability to enhance the capacity of the occupational therapist to meet the needs of the people served, therefore it is vital that models identify the systemic barriers that prevent people from attaining a meaningful life premised on notions of positive health.*

In conclusion about the value of the Kawa Model in the present study, I would like to appraise the Kawa Model (within the context of this study), to the statement above. In my own interpretation of Urbanowski's (2005:302) words: the Kawa Model enhances the capacity of the occupational therapist to meet the needs of the

Sesotho speaking adult with mental health problems, by allowing her to identify the systemic barriers to a meaningful life for the patient.

5.3 GENERAL RECOMMENDATIONS; WITH SOME IMPLICATIONS FOR OCCUPATIONAL THERAPY

The findings discussed in 5.2; provided a better understanding of the occupations and socio-cultural context of the Sesotho speaking adult with mental health problems. I will now attempt to infer, from these findings, certain recommendations with regards to culturally relevant therapy for these patients.

Before embarking on this discussion of recommendations, it is important to note that in this qualitative study, generalization is not the aim. Rather, transferability is encouraged: whereby a colleague could scrutinize the study and learn from the sample, findings and recommendations; and then carefully apply similar strategies in her/his practice.

5.3.1 Recommendations with regards to the content of an occupational therapy program

The following recommendations stem from a 'list of problems' in occupational functioning, drawn up throughout the findings. These topics are recommended for inclusion in the group therapy program, or individual intervention if appropriate. (Guidelines for presentation of therapy are made in 5.3.2). In 2.1, health has been described from three viewpoints, more importantly (in the current study) those of health as a state of personal ability and adaptation, but also of health as social equity and opportunity. Once again, I will reiterate that this study hopes to provide information that would allow therapists to provide programs appropriate for the population – which would increase 'social equity and opportunity' and therefore the

health of participants. However, the recommendations provided in this section – with a view on the content of a therapy program – is aimed at health as 'personal ability and adaptation'.

- Social skills training are recommended, specifically in assertive communication, communication within the marriage and general conflict management.
- Self-esteem needs to be strengthened by improved knowledge of self and self-awareness pertaining to self knowledge.
- Patients need to be informed on sleep hygiene. Some aspects of sleep hygiene may be practised in occupational therapy, for example relaxation therapy; which can then be done by the insomniac patient prior to bedtime.
- Occupational therapy in mental health mostly include as priority, an improved understanding in the patient of the importance and possibilities surrounding leisure. In this population however, the occupational therapist may need to make a mind shift from the traditional conceptualization of occupations (work, sleep, leisure etc.), and actively adopt recent theoretical developments on the complexity of occupational balance: as Pierce argues all occupations can offer Restoration, Productivity and Pleasure. The aim would now be to facilitate an understanding in patients of how to recognize and incorporate these three characteristics into a balanced daily life.
- Exposing patients to novel leisure activities may prove beneficial in this process of learning to recognize aspects of Restoration, Productivity and Pleasure in themselves.
- Principles of basic and simple personal financial management may be incorporated into the occupational therapy program, provided it is to facilitate improved skills in personal management and independence. (I.e. financial advice

would not be the aim, rather to teach patients simple skills of budgeting and saving).

5.3.2 Recommendations with regards to the presentation of occupational therapy

With recommendations regarding the content of the program made above, I will now provide broad guidelines for presenting group therapy to the population.

- Groups are considered an effective treatment modality in the specific population. Against the background of *ubuntu,* it can be explained that aspects of group dynamics, i.e. altruism, universality and cohesion, are also associated with *ubuntu.* Groups may therefore benefit the Sesotho speaking adult with essential social support and a place of belonging, even before the content of the group sessions have an impact.

- Having mentioned *ubuntu*, the practical implications of this socio-cultural value have to be considered in occupational therapy practice in group sessions. For example, when offering knowledge and skill to patients in assertive communication, not to expect of patients to feel comfortable with saying 'no' to a brother or sister wanting to borrow money. That will be to expect the person that the occupational therapist is working with to act outside of the philosophy of *ubuntu*.

- The consideration of other cultural aspects may also be necessary, for example when covering communication within marriage, it should be considered that the female patient may be expected to act subordinately to her husband; and the male patient may expect his wife to act similarly.

- Participants expressed three values very strongly: involvement in family and community; maintaining a positive mindset and engaging in spiritual and

religious activities. These values have to be considered and allowed for in all aspects of therapy: screening, assessment, intervention and evaluation. A positive mindset, for example, could be seen in screening where a patient is stating that 'everything will be all right'; and in assessment with optimistic answers not necessarily reflecting the true situation. In intervention and evaluation, the patient may report positive results and/or feelings, in the spirit of maintaining a positive mindset. This needs to be challenged in therapy if it entails a repressive coping mechanism, but on the other hand, if not challenged, then acknowledged and allowed by the therapist.

- In order to relieve the stigma surrounding mental illness, psycho-education, for patients and if possible their families, is essential in the occupational therapy program. In planning the psycho-educational program, a therapist has to look at the cultural aspects of health as identified by Gilbert *et al.* (1996:49) in 4.2.4.4.

- Based on participants positive experiences of sharing their narratives, I would recommend that patients be invited to and allowed more time to share their narratives in occupational therapy groups. This may facilitate a sense of relief, and in combination with the group dynamic factors of cohesion and universality, provide the patient with a sense of *ubuntu* within his therapeutic group; resembling Krog's (2008) notion of *ubuntu* as an interconnectedness-towards-wholeness. Patients may appreciate a therapist's effort to greet them in their own language (Sesotho), as a sign of respect and acknowledgement.

- The therapist may need to adapt her therapeutic self to resemble *ubuntu* and a respectful manner towards male persons.

- The therapist needs to consider the socio-cultural context of her *pati*ents throughout all the steps of therapy. Again, Lim's (2009:85) statement is used as a starting point:

> *Whatever information I think I have on the culture of a patient, it has to be verified with the client, who can then supplement if necessary.*

This statement reminds me to tread careful around the cultures of other people. Before I consider a patient's culture in therapy with great fanfare and enthusiasm, it may be worth my time to verify the information I thought applicable, with said patient.

In light of the hesitations above, the following aspects are listed as possible considerations in therapy:

- Subcultures exist within any culture, also the Basotho culture. I can therefore not assume all patients to have the same opinions, needs and customs.
- Participants expressed considerable distress in the face of a changing culture. They experienced factors of modernization (i.e. urbanization) as the catalysts for this change. The questions I need to consider, are: Will my therapy be yet another challenge for my patient's culture? Will I be another external force requiring my patient to neglect and dishonor his/her culture?
- I need to consider that some of my patients' customs may seem very strange to my background. I therefore need to remind myself to remain non-judgmental even if I do not understand, for example, the need to slaughter an animal a day of two prior to the funeral of the deceased.
- The impact of customs on occupational participation need to be considered. I.e. if my patient is in the mourning process, I would not encourage her to attend extra-curricular activities at night (even if it is therapy), since she would be required to be home after dark.

- Females are regarded as subordinate to men, and elders are to *be respected* at all times, lest they withdraw their support. These social structures need to be honored by the therapist in group therapy. For example, I would not expect a young person to engage in the type of role play with an elder that would provide awkward situations, which in turn would prove to be ineffective.

5.4 RECOMMENDATIONS FOR FURTHER RESEARCH

Based on the findings and limitations of the present study, recommendations are made regarding future research regarding culturally relevant therapy for the Sesotho speaking persons with mental health problems.

- The study may be repeated in other settings (i.e. state hospitals), with similar samples in order to enhance any possibility of transferability.

- The study may also be further explored in the same or similar settings. For example, the findings from the focus group could be presented to a focus group, who could analyze, criticize and supplement the findings from the present study.

- An ethnographic study, where a researcher would live with the informants, may provide invaluable and first-hand knowledge on the experiences of the Sesotho speaking adult with mental health problems, admitted to a Clinic.

- Unstructured interviews, without any prompts and tools for deduction, may provide information for an alternative conceptualization of occupations.

- Since participants often reverted to Sesotho during interviews and the focus group, it may be worthwhile exploring the possibilities of conducting this study in Sesotho, or at least having a Sesotho research assistant present at all times. This may add some valuable information that have now been lost due to the researcher's inability to understand Sesotho.

- This study confirmed the value of being open for alternative conceptualizations of occupations, as influenced by socio-cultural contexts. Everyday assumptions on occupational performance within specific socio-cultural contexts can be explored in studies similar to this one, to enhance the relevance of occupational therapy in different settings.

5.5 LIMITATIONS OF THE STUDY

The following aspects are described as limitation to the present study:

- The sample was restricted to two clinics in the private sector, implying that most patients had medical aids (in order to enable hospital stay), which points to a slightly higher socio-economic status than many other Sesotho speaking adults with mental health problems.

- The sample was relatively small, even though in line with the prescribed numbers for a collective case study. Saying that, readers are reminded once again that the aim is not the generalize findings for application with all Sesotho speaking adults. Rather, cultural responsiveness can lead the OT to enquire appropriately about the culture of her patient, to enable her to provide culturally relevant therapy.

- The Kawa Model was applied in a deductive way; or at least the interviews were conducted in a deductive way. As mentioned previously, if the interviews were conducted more in-depth and with less direction, a different conceptualization of occupations may have emerged from the findings.

- A dearth of literature with regard to Sesotho speaking adults with mental health problems, in the current South Africa, limited the background reading to the study. At the same time, literature on the use of the Kawa model with South

African populations, was scarce. Appropriate sources may have enabled me to bound the limitation described above (cf. 5.5.4).

- A foreseen limitation of the study, was the issue of language. The participants were, per definition, Sesotho speaking. Even so, all processes of data collection were conducted in English; due to practical reasons. Participants, especially those in the focus group, often reverted to Sesotho during the interviews; which could point to a loss of valuable data.

- Another foreseen limitation of the study, was the lack of opportunity to do member checking. This strategy would have allowed the researcher to check with participants that transcriptions were correct, but at the same time to elaborate on findings as understood by the researcher.

5.6 CLOSURE

The aim of the study was reached – in that the findings of the present study allowed the researcher to understand more about the occupations and socio-cultural context of the Sesotho speaking person with mental health problems. Considering their occupations and socio-cultural context, would allow the occupational therapist to cultivate occupational therapy to suit the meaning of her patient's world (cf. Figure1.1). Based on this improved understanding of the population's occupations and socio-cultural context, recommendations with regards to culturally relevant practice were made.

This chapter and dissertation is closed with the same question asked in the first paragraph of Chapter 1:

> *Can we truly help another human being without knowing what he or she experiences..? (Yerxa 2009:492)*

I still believe the answer to this question to be 'no'. I do need to understand something of my patient's occupational experience within his socio-cultural context, as attempted in this study. However, even this 'understanding' has to be applied with care, as noted by one of the participants, Masabatha:

> *What is really important, is that everybody's needs are*
>
> *individual and different, not necessarily because of culture.*

I close this study with a quote from Janet Amegatcher (2011), who presented the official 'Consumer's Lecture' at the 2011 World Mental Health Congress in Cape Town. She spoke about the involvement of Mental Health Care Service Users' involvement in the planning of services, and made the following powerful statements:

> *We are the knowers and yet we remain the untapped resource.*
>
> *We want to be listened to.*
>
> *We invite you to walk beside us.*
>
> *We know where we want to go.*

This study was a first step, in - hopefully - the direction of culturally relevant occupational therapy for the Sesotho adult with mental health problems.

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Appendix A:

Literature searches conducted for the review of literature

The table below contains details and results of searches conducted for the review of literature.

SEARCHES COMPLETED ON EBSCHOHOST (via www.ufs.ac.za)					
Searh keywords (Any or all)	**Full text / References**	**Period**	**Number of results**	**Number of results appropriate**	**Databases searched**
Occupations; Socio-cultural context; Sesotho speakers.	Full text	2000-2011	279	0	Academic search complete
Occupations; Sesotho speakers.	All text	2000-2011	17	0	Academic search complete
Occupations; Sotho; Socio-cultural.	All text	2000-2011	18	0	*Academic Search Complete *CINAHL with Full Text *Health *Source:Nursing/ Academic edition *Medline with Full Text *PsycARTICLES
Occupational therapy; Sotho.	All text	2000-2011	30	0	As above

**These databases have been confirmed by staff at Frik Scott Library (UFS), to be appropriate for the purposes of this study.*

Searh keywords (Any or all)	Full text / References	Period	Number of results	Number of results appropriate	Databases searched
Mental health AND Sotho	Full text	2000-2011	240	1	As above
Cross-cultural AND Occupational therapy AND Sotho	All text	2000-2011	9	0	As above
Cross-cultural AND Occupational therapy	All text	2000-2011	9807	Not	As above
Cross-cultural AND Occupational therapy AND Sotho	All text	2000-2011	9	0	As above
Kawa model; Occupational Therapy.	All text		6	3	As above

APPENDIX B:

INTERVIEW SCHEDULE

Short questionnaire : Biographic information

Participant:

……

1 Date questionnaire is completed (dd/mm/yy) ……./……../2011

2 What is your sex?

Male(1)	Female(2)

3 What is your age?

……years

4 What is your highest qualification?

……

5 What is your occupation (daily job)?

……

6 How would you describe your employment?

Permanently employed (full-time)	
Permanently employed (part-time)	
Employed on contract	
Self-employed	
Unemployed	

7 With which ethnic group do you identify?

For example Chinese or Khoi

……

8 Which language do you speak most **at home?**

	Sesotho
	Setswana
	IsiXhoza
	IsiZulu
	English

	Afrikaans
	Other, specify……..

Which language do you speak most **at work?**

	Sesotho
	Setswana
	IsiXhoza
	IsiZulu
	English
	Afrikaans
	Other, specify……..

9 What is your marital or relationship status?

	Single
	Married/Traditional marriage
	Divorced/Separated
	Widow/Widower
	In a relationship - living together
	In a relationship - not living together
	Other (Specify:……)

MEN: If you are married, how many wives do you have? //

10 **WOMEN:** If you are married, how many wives do your husband have?

11 Identify the life-roles you have at the moment.
(Tick as many as you want)

Spouse (husband / wife)	
Relationship partner	
Parent	
Friend	
Child	
Sibling (brother / sister)	
Carer	
Student	
Worker	
Colleague	
Neighbour	
Churchgoer	
Other.....	

12 Please specify your religion:

Christian Evangelical or Protestant	
Christian: African traditional (ZCC)	
Islam	
Hindu	
Other.....	
None	

13 In which life-roles are you experiencing problems at the moment?

Spouse (husband / wife)	
Parent	
Step / foster parent	
Child	
Carer	
Student	
Worker	
Colleague	
Neighbour	
Friend	
Churchgoer	
Other.....	

14 What is your main reason for admission to Care Cure Clinic?

…….

15 Do you know if you have been diagnosed by the psychiatrist?

Yes	No

If yes, please specify your diagnosis (main diagnosis for this admission).

……

16 Is this your first admission to Care Cure Clinic or similar clinics?

Yes	No

17 If NO, please specify how many times you have been admitted to Care Cure Clinic or similar clinics, for mental health reasons.

.....

18 What do you need from this admission to Care Cure Clinic?

Medication	
Counselling (individual)	
Counselling (marriage)	
Group therapy	
Other:……	

19 Do you need the following topics to be covered during group therapy?

Stress	Yes	No
Time management	Yes	No
Recreation & leisure	Yes	No
Relaxation therapy	Yes	No
Problem solving	Yes	No
Communication skills	Yes	No
How to say no	Yes	No
Dealing with losses & grief	Yes	No
Getting to know yourself	Yes	No

20 What other topics would you suggest for the group therapy program?

Better sleeping	
Finance & budgeting	
Disciplining your kids	
Other:……	
……..	
……..	

21 Do you feel the current group therapy program is taking into account your cultural background?

Yes	No

If NO, please motivate your answer:

……

22 Are there any 'cultural aspects' that you need to be taken into consideration in the group therapy program, in order to make the program more suitable to your needs?

Yes	No

If YES, please specify:

……

Switch on digital recorder

Proceed with interview according to the Kawa Model

Following completion of the questionnaire above, the researcher will proceed with the interview:

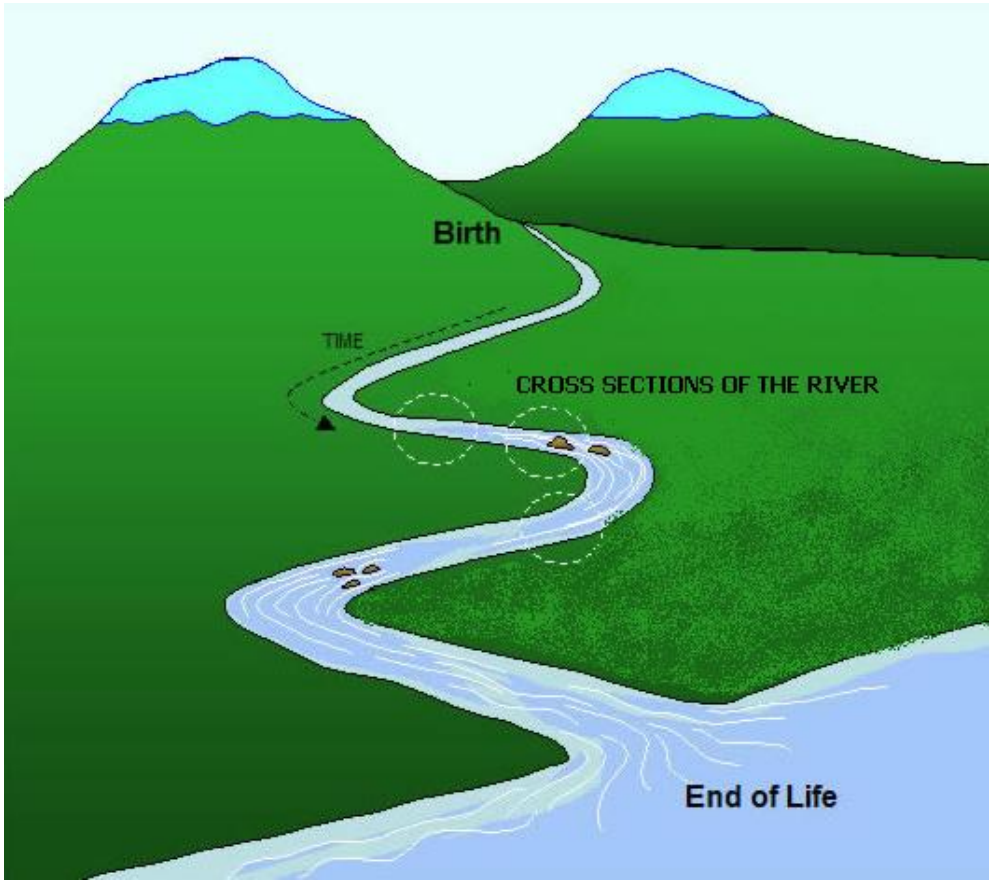


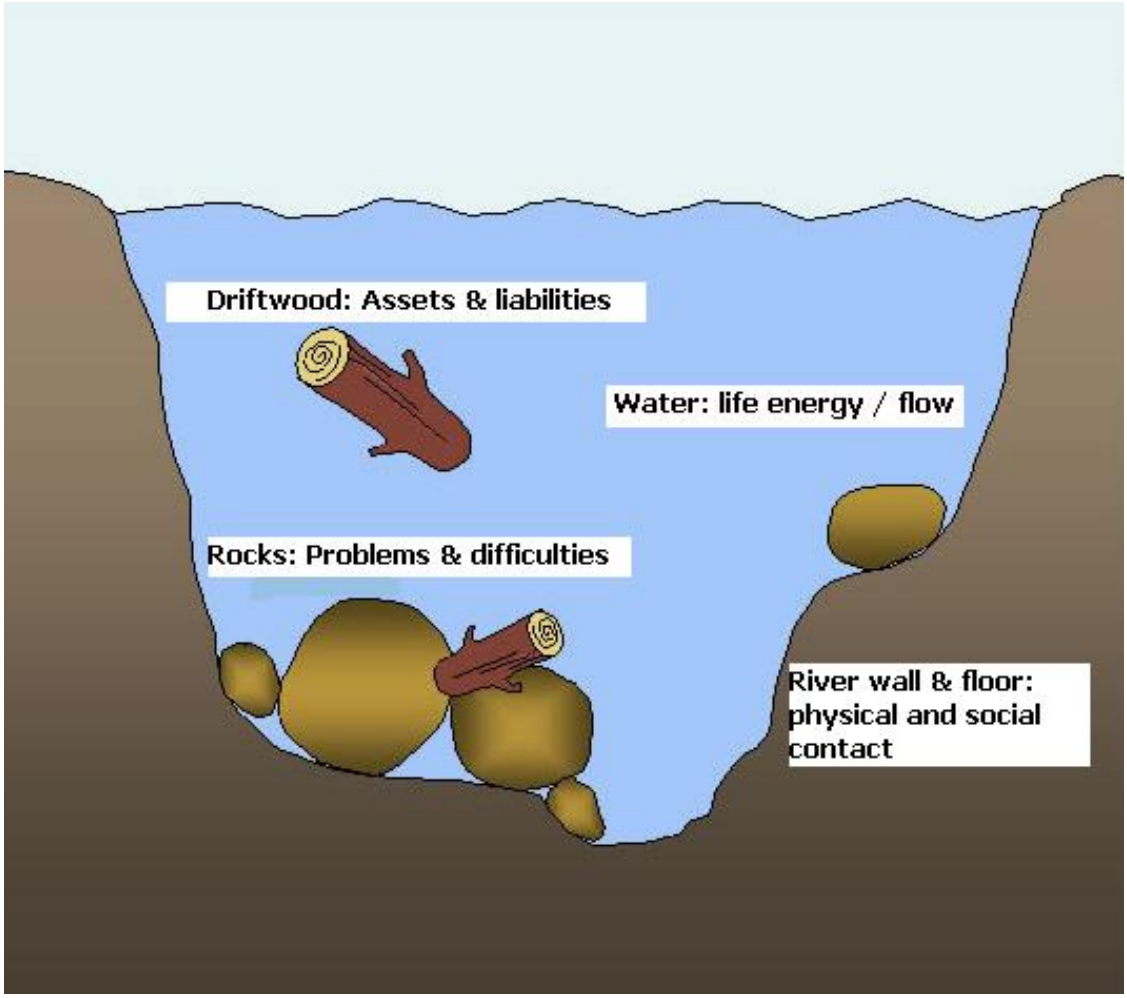
Figure B: "Life is like a river, flowing from birth to end of life" (Iwama 2010:online)

- Explain the Kawa model metaphor of 'life as a river' , according to the figure below.
- Explain the following river-related terms according to the figure below:
    - Rocks = circumstances preventing 'flow'

- Walls and bottom = environment
- Driftwood = assets and liabilities
- Water = the flow of life

Figure C: "A cross section view of the river" (Iwama 2010:online)

- Initiate discussion of a 'cross section' of the participant's life *immediately prior to admission to The Clinic*. Invite participant to draw his own. If not, use Figure B to



guide the conversation.

- Probe occupations, i.e.
- Work

- Leisure
- Sleep
- Social functioning and
- Personal management and responsibilities.

- Clarify the main topics discussed during the interview.

Appendix C:

Information document for individual interviews (English & Sesotho)

UNIVERSITEIT VAN DIE VRYSTAAT
UNIVERSITY OF THE FREE STATE
YUNIVESITHI YA FREISTATA

Dept. of Occupational Therapy
CR de Wet Building
University of the Free State
Bloemfontein, 9300
January – February 2011

Dear ……..(name of participating patient)

RE: OCCUPATIONAL THERAPY RESEARCH PROJECT AT THE CLINIC

You are hereby invited to participate in an interview with myself, Mia Vermaak (occupational therapist), as part of a research project conducted at The Clinic.

The results of this study may lead to changes being made to the current program, according to information obtained during the interviews.

This document includes core information; and more detail is available from myself.

PURPOSE OF THE STUDY

The purpose of the study is to describe how Sesotho patients experience their daily participation in occupation.

APPROVAL OF THE STUDY

The study has been approved by the Ethics Committee of the University of the Free State (UFS). (Ethics number 150/2010)

RESEARCH PROCEDURES

- As indicated above, you may be asked to participate in a single interview with the researcher, Ms. Mia Vermaak (occupational therapist).
- It will only take an hour of your time; and will take place in a consultation or group therapy room at The Clinic.
- Participation in the interview will not interfere with your group program OR individual appointments with your doctor or psychologist.
- The interview will be recorded, to allow the researcher to get the correct information from the interview.

POPULATION INVOLVED

- Any patient attending the English group therapy program at The Clinic, may be invited to participate in this study.
- The researcher has the right to prohibit a patient from participating in an interview or group session, due to criteria approved by the Ethics Committee.

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 you as patient in the short term, but may lead to alteration to the current program. This in turn may benefit other people admitted to The Clinic.

- in the future.
- Treatment, intervention or counseling will not be offered during any of the sessions, which will follow strict research procedures as approved by the Ethics Committee of the UFS.

ALTERNATIVES TO PARTICIPATION

- Choosing not to participate will not in any way lead to discrimination or ill-treatment during your stay at The Clinic.

COMPENSATION, COSTS AND REIMBURSEMENT (to participants)

Compensation or reimbursement

No reimbursement will be offaered, and no extra occupational therapy intervention will be offered following the interview.

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 you are free to withdraw from this study at any time without penalty or prejudice.

CONFIDENTIALITY

- All questionnaires and interview sheets will be coded, without using participants' names.
- The identity of all participants will be treated confidentially.
- Information obtained during interviews, 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, 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.

NEW FINDINGS

If, during the course of this study, significant new information becomes available that may relate to your willingness to continue to participate in the study, this information will be provided to you by the researcher.

Thank you,

Ms. Mia Vermaak	Dr. R van Heerden	Ms. T van der Merwe
Occupational Therapist	Study leader	Co-study leader
miavermaak@googlemail.com	Senior Lecturer	Lecturer
B. Occ. (UFS; 2003)	Dept. OT, UFS	Dept. OT, UFS
Tel: 079 921 2277	Tel: 051 401 2829	Tel: 051 401 2829

I declare that I have read this document. I understand the risks and benefits from participating in the study.

I, ……, hereby give my consent to participate in an interview conducted by the researcher for the purpose of this study.

…… …….

Participant signature Date

I have explained this study to the participant as identified above and have sought his/her understanding for informed consent.

…… ……

Researcher signature Date

UNIVERSITEIT VAN DIE VRYSTAAT
UNIVERSITY OF THE FREE STATE
YUNIVESITHI YA FREISTATA

Dept. of Occupational Therapy
University of the Free State
Bloemfontein, 9300

January – February 2011

Ho monghadi/Mofumahadi.....(lebitso la motho ya nkang karolo)

LE:PATLISISO YA OCCUPATIONAL THERAPY KLINIKING YA CURE CLINIC VICTORIA GARDENS.

Mona re o mema ho nka karolo puisanong le nna, Mia Vermaak (occupational therapist), eleng karolo ya projeke ya patlisiso e tla tshwarelwa The Clinic. Sephetho sa patlisiso ena se ka tlisa diphethoho ka baka la puisano ya rona yo ya ka metjha e sebediswang ha jwale. Tokomane ena e tswere dintlha tsa bohlokwa mabapi le dipatlisiso; dintla tse ding dika fumaneha ho nna.

LEBAKA LA DIPATLISISO

Moko taba wa patlisiso ena ke ho bokkella dikeletso ka moetlo o nepahetseng ka Occupational Therapy ho bakudi ba etelang sehlopha sa dithuso tsa Occupational Therapy The Clinic.

NETEFATSO YA PATLISISO

Patlisiso ena e netefaditswe ke komiti ya tsa boitswaro ba botho Yunivesiting ya Freistata(UFS).(nomoro ya tsa boitswa-ro ba botho.....)

TSAMAISO YA PATLISISO

Jwaloka ho bontshitswe hodimo,o ka lebella ho kopuwa ho onka karolo ya bo mong puisanong le mmatlisisi; Mia Vermaak (Occupational Therapist). E tla nka feela hora ele nnwe ya nako ya hao; e tla twarelwa phapusing ya dipuisano kapa phapusing ya tlabollo ya The Clinic.

. Ho nka karolo puisanong ena ho kekebe hwa kena-kenana le sehlopha sa dithuso tsa hao kapa nako ya hao ya ya tumellano le ngaka kapa mohlabolli wa hao wa maikutlo.

SETJHABA SE NKANG KAROLO

Mokudi ofe kapa ofe ya tsamayang sehlopheng sa tlhabollo ya senyesemane The Clinic aka memelwa ho nka karolo patlisisong ena. Mmatlisisi ona le tokelo ya ho hanela mokudi ho nka karolo puisanong kapa sehlopheng sa nakwana ka lebaka la dintlha tse netefaditsweng/tse fanwang ke ke komiti ya tsa boitshwaro ba botho.

TSIETSI TSA TSHOHANYETSO LE TLHOKO YA BOTSITSO

Ha ho ditsietsi tsa tshohanyetso tse tsebahalang kapa ho hloka botsitsi bo amahantshwang ke tsamaiso e patlisisong ena.Ho nka karolo ke boithaopo.

MELEMO

Patlisiso ena e kanna ya se o tsele molemo ha jwale jwaloka mokudi, empa eka tlisa diphethoho metjheng ya ha jwale. Hona ho ka boela hwa etsa molemoho batho ba tla amohelwa setsing sena ka moso.

Kwetliso, dipuisano tse kgetheileng kapa tlabollo ya maikutlo di ke ke tsa fumaneha nakong ya mosebetsi ona otla latela tsamaiso e matla e nnetefaditsweng ke komiti ya tsa buitshwaro ba botho ya UFS.

MEKGWA E MENG YA HO NKA KOROLO

Ho kgetha ho se nke karolo ho keke hwa baka kgethollo kapa tlhekefetso nakong ya bodulo ba hao The Clinic.

KHOTHATSO, PATALA LE TSHENYEHELO (tsa honka karolo)

KHOTHATSO LE TSHENYEHELO

Ha ho tshenyehelo tse tla patalwa, kapa tlhabollo e kgetheileng e tla fanwa kamora dipuisano.

PATALA

Patala tsohle di boikarabellong ba mmatlisisi, hape ha hona patala etla batlwa ho ba nkang karolo.

HO TLOHELA KAPA HO EMISA KA THUTO

Ho nka karolo ke ka boithaopo hape motho o dumeletswe hore aka tlohela efe le efe ha a batla ntle le ho fumatshwa kotlo kapa ho kgetholwa.

LEKUNUTU

Dipotso tsohle le dipuisano di tla phatlalatswa ntle le ho sebedisa mabitso a ba nkang karolo.

Boitsebiso ba batho ba nkang karolo bo tla bolokwa ele lekunutu.

Dintlha tse tla fumanwa dipotsong kapa dipuisanong di tla bolokwa ele lekunutu.Ha ho ka mokgwa oo lebitso la ya nkang karolo le ka phatlalatswa setjhabeng ke mmatlisisi kapa ka mokgwa oo dintlha tsa yang nkang karolo ditla phatlalatswa ka tsela etla hlokomeleha setjhabeng hore na ke mang.

Dintlha tse tla fumanwa ditla fumaneha ho mmatlisisi, baetelli pele, le ba palo ya setjhaba ba Yunivesiti ya Freisitata. Le tsona di bewa lekunutung ka tsela e tswanang le mmatlisisi, hape dintlha tsena di tla tswarwa ele lekunutu ka mo-kgwa o phahameng.

DIPHUMANO TSE NTJHA

Haeba nakong ya boithuto ho ka fumaneha dintlha tsa bohlokwa tse amanang le thato ya hao ya ho tswapele ka ho nka karolo dithutong tsena, dintlha tseo o tla difuwa ke mmatlisisi.

MOKGWA WA HO FUMANA MMATLISISI

Mmatlisisi:	Moetapele wa dipatlisisi:	Motlatsi wa moetapele wa dipatlisiso:
Ms. Mia Vermaak	Dr. S.M. van Heerden Hloho: Department ya Occupational Therapy, UFS Tel: 051 401 2829	Mrs. T. van der Merwe Morutwa bana: Dept ya Occupational Therapy Tel: 051 401 2829

Ka teboho

Mia Vermaak

Ke tiisa hore ke babile tokomane ena ka hloko. K e utlwisisa ditsietsi tsa tshohanyetso le melemo ya ho nka karolo patlisisong ena.

Nna,....., mona ke itlama ho nka karolo puisanong etla tshwarwa ke mmatlisisi molemong wa patlisiso ena.

....

Boitsibiso bo kgetheileng Letsatsi

Ke hlalositse thuto ena ka botlalo ho ya nkang karolo jwaloka ha ho bontshitswe tokomaneng e ka hodimo, mme ke batlile kutlwisiso ya hae mabapi le tumellano ya ho nka karolo.

....

Researcher Letsatsi

Appendix D:

Information document –

Participants to the Focus Group

UNIVERSITEIT VAN DIE VRYSTAAT
UNIVERSITY OF THE FREE STATE
YUNIVESITHI YA FREISTATA

Dept. of Occupational Therapy
CR de Wet Building
University of the Free State
Bloemfontein, 9300
25 August 2011

RE: OCCUPATIONAL THERAPY RESEARCH PROJECT AT THE SECOND CLINIC

You are hereby invited to participate in a group interview with myself, Mia Vermaak (occupational therapist), as part of a research project conducted at The Second Clinic. The results of this study may lead to changes being made to the current program, according to information obtained during the interview.

This document includes core information; and more detail is available from myself.

PURPOSE OF THE STUDY

The main aim of this study is to compile guidelines on culturally suitable occupational therapy for the patients attending the occupational therapy group program at The Second Clinic.

APPROVAL OF THE STUDY

The study has been approved by the Ethics Committee of the University of the Free State (UFS).

RESEARCH PROCEDURES

- As indicated above, you are requested to participate in a once-off group interview with the researcher, Ms. Mia Vermaak (occupational therapist).
- It will only take an hour of your time; and will take place in a group therapy room at The Second Clinic.

- Participation in the interview will not interfere with your group program OR individual appointments with your doctor or psychologist.

POPULATION INVOLVED

- Any patient attending the English group therapy program at The Second Clinic, may be invited to participate in this study.
- The researcher has the right to prohibit a patient from participating in the group interview, due to criteria approved by the Ethics Committee.

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 you as patient in the short term, but may lead to alteration to the current program. This in turn may benefit other people admitted to The Second Clinic in the future.
- Treatment, intervention or counseling will not be offered during any of the sessions, which will follow strict research procedures as approved by the Ethics Committee of the UFS.

ALTERNATIVES TO PARTICIPATION

- Choosing not to participate will not in any way lead to discrimination or ill-treatment during your stay at The Second Clinic.

COMPENSATION, COSTS AND REIMBURSEMENT (to participants)

Compensation or reimbursement

No reimbursement will be offered.

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 you 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 interview, 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 and the study leaders 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.

NEW FINDINGS

If, during the course of this study, significant new information becomes available that may relate to your willingness to continue to participate in the study, this information will be provided to you by the researcher.

Thank you,

Ms. Mia Vermaak
Occupational Therapist
miavermaak@googlemail.com
B. Occ. (UFS; 2003)
Tel: 051 502 1807

Dr. R van Heerden
Study leader
Senior Lecturer
Dept. OT, UFS
Tel: 051 401 2829

Ms. T van der Merwe
Co-study leader
Lecturer
Dept. OT, UFS
Tel: 051 401 2829

I declare that I have read this document. I understand the risks and benefits from participating in the study.

I, ……, hereby give my consent to participate in the group interview conducted by the researcher for the purpose of this study.

…… …….

Signature Date

I have explained this study to the participant as identified above and have sought his/her understanding for informed consent.

……. ……

Researcher signature Date

Appendix E:

Information document –

Management of The Clinic

UNIVERSITEIT VAN DIE VRYSTAAT
UNIVERSITY OF THE FREE STATE
YUNIVESITHI YA FREISTATA

Dept. of Occupational Therapy
CR de Wet Building
University of the Free State
Bloemfontein, 9300
(Date)

Dear ……..

The purpose of this document is to obtain your consent for conducting a research study at the The Clinic. The document contains core information on the study, and detailed information is available from the researcher, Ms. Mia E. Vermaak.

RESEARCHER

Ms. Mia E. Vermaak (HPCSA nr: OT 0061557); Occupational therapist & Magister Student: Dept. of Occupational Therapy, UFS. The study is conducted in fulfillment of the requirements for a Magister Degree in Occupational Therapy at the UFS.

DATES

February – March 2011

PURPOSE OF THE STUDY & RESEARCH PROCEDURES

The purpose of the study is to describe how Sesotho patients experience their daily participation in occupation.

APPROVAL OF THE STUDY

The study has been approved by the Ethics Committee of the University of the Free State (UFS). (Ethics nr. 150/2010).

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 patients in the short term, but may lead to alteration to the current program. This in turn may benefit other people admitted to The Clinic in the future.
- Treatment, intervention or counseling will not be offered during any of the sessions, which will follow strict research procedures as approved by the Ethics Committee of the UFS.

ALTERNATIVES TO PARTICIPATION

- Choosing not to participate will not in any way lead to discrimination or ill-treatment during a person's stay at The Clinic.

COMPENSATION, COSTS AND REIMBURSEMENT (to participants)

Compensation or reimbursement

No reimbursement will be offered, and no extra occupational therapy intervention will be offered following the interview.

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

- All questionnaires and interview sheets be coded, without using participants' names.
- The identity of all participants will be treated confidentially.
- Information obtained in questionnaires, or during interviews, 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, the study leaders and co-coders 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 be mentioned in any publications on this study.

NEW FINDINGS

If, during the course of this study, significant new information becomes available that may relate to participants' willingness to continue to participate in the study, this information will be provided to them by the researcher.

Thank you,

Ms. Mia Vermaak
Occupational Therapist
miavermaak@googlemail.com
B. Occ. (UFS; 2003)
Tel: 051 502 1807

Dr. R van Heerden
Study leader
Senior Lecturer
Dept. OT, UFS
Tel: 051 401 2829

Ms. T van der Merwe
Co-study leader
Lecturer
Dept. OT, UFS
Tel: 051 401 2829

Appendix F:

Information document –

Management of The Second Clinic

UNIVERSITEIT VAN DIE VRYSTAAT

UNIVERSITY OF THE FREE STATE

YUNIVESITHI YA FREISTATA

Dept. of Occupational Therapy

CR de Wet Building

University of the Free State

Bloemfontein, 9300

(Date)

Dear ……..

The purpose of this document is to obtain your consent for conducting a research study at The Second Clinic. The document contains core information on the study, and detailed information is available from the researcher, Ms. Mia E. Vermaak.

RESEARCHER

Ms. Mia E. Vermaak

Occupational therapist & Magister Student: Dept. of Occupational Therapy, UFS.

HPCSA nr: OT 0061557

The study is conducted in fulfillment of the requirements for a Magister Degree in Occupational Therapy at the UFS.

DATES

August 2011

PURPOSE OF THE STUDY & RESEARCH PROCEDURES

The purpose of the study is to describe how Sesotho patients experience their daily participation in occupation.

A single focus group interview will be conducted at The Second Clinic, with the invitation extended to all Sesotho speaking adult patients. The interview will be conducted by myself, in a group therapy room at The Second Clinic.

APPROVAL OF THE STUDY

The study has been approved by the Ethics Committee of the University of the Free State (UFS). (Ethics nr. 150/2010).

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 patients in the short term, but may lead to alteration to the current program. This in turn may benefit other people admitted to The Second Clinic in the future.
- Treatment, intervention or counseling will not be offered during any of the sessions, which will follow strict research procedures as approved by the Ethics Committee of the UFS.

ALTERNATIVES TO PARTICIPATION

- Choosing not to participate will not in any way lead to discrimination or ill-treatment during a person's stay at Care Cure Clinic.

COMPENSATION, COSTS AND REIMBURSEMENT (to participants)

Compensation or reimbursement

No reimbursement will be offered, and no extra occupational therapy intervention will be offered following the interview.

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 interview, 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, the study leaders and co-coders 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 Second Clinic, will not be mentioned in any publications on this study.

NEW FINDINGS

If, during the course of this study, significant new information becomes available that may relate to participants' willingness to continue to participate in the study, this information will be provided to them by the researcher.

Thank you,

Ms. Mia Vermaak
Occupational Therapist
miavermaak@googlemail.com
B. Occ. (UFS; 2003)
Tel: 079 921 2277

Dr. R van Heerden
Study leader
Senior Lecturer
Dept. OT, UFS
Tel: 051 401 2829

Ms. T van der Merwe
Co-study leader
Lecturer
Dept. OT, UFS
Tel: 051 401 2829