

University Of Kwazulu-Natal
College Of Health Sciences
Discipline Of Occupational Therapy

**Addressing Spirituality in Group Therapy:
A Qualitative Study at a shelter for Abused and Vulnerable Muslim
Women in Durban, South Africa**

Nazeemah Soomar
9401439

Research report submitted in partial fulfillment of MPhil Group Work
Therapy

Supervisor: Professor Rosemary Crouch

Ethical Clearance Number: HSS/1284/012M

Date: February 2016

SUPERVISORS' PERMISSION TO SUBMIT FOR EXAMINATION

Student: Nazeemah Soomar

Student Number: 9401439

Dissertation Title:

Addressing Spirituality in Group Therapy:
A Qualitative Study at a shelter for Abused and Vulnerable Muslim
Women in Durban, South Africa

As the candidate's supervisor, I AGREE to the submission of this
dissertation for examination

SUPERVISOR

PROFESSOR R. CROUCH

SIGNATURE: RBCrouch

DATE: 8 FEBRUARY 2016

DECLARATION

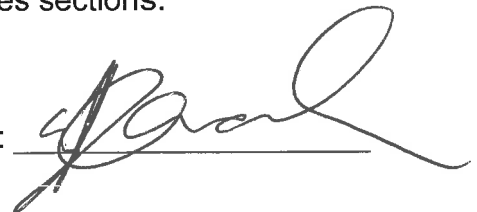
I, Nazeemah Soomar. student number 9401439, declare that:

- i. The research reported in this dissertation, except where otherwise indicated, is my original work. It is my original work, both in concept and execution, and that apart from the normal guidance from my supervisor, I have had no assistance in writing this dissertation.
- ii. This dissertation has not been submitted for any degree or examination at any other university.
- iii. This dissertation does not contain other persons' data, pictures, graphs or other information, unless specifically acknowledged as being sourced from other persons.
- iv. This dissertation does not contain other persons' writing, unless specifically acknowledged as being sourced from other researchers. Where other written sources have been quoted, then:
 - a. Their words have been re-written but the general information attributed to them has been referenced;
 - b. Where their exact words have been used, their writing has been placed inside quotation marks, and referenced.
- v. Where I have reproduced a publication of which I am an author, co-author or editor, I have indicated in detail which part of the publication was actually written by myself alone, and have fully referenced such publications.
- vi. This dissertation does not contain text, graphics or tables copied and pasted from the internet, unless specifically acknowledged, and the source being detailed in the dissertation and in the References sections.

Nazeemah Soomar

Date: February 2016

Signed: _____



Professor Rosemary Crouch

Date: February 2016

Signed: _____

RBCrouch

DEDICATION

I dedicate this dissertation to the women in my lineage, who often claim to be uneducated in my shadow, but whose level of endurance, perseverance and commitment I may never attain.

What then, I ask, is true education?

To My Grandmothers and My Mother: My education is your education.

To my Daughter, Fatimah Zahra: The day you decorated my file for the first day of this course, and packed my pencil case, I knew I had to do it for you. May you soar to heights of true education.

ACKNOWLEDGEMENTS

Ya Shakur (The Most Thankful)

My most humble appreciation to Allah, my spiritual mentor Murshid Shaykh Taner Ansari, and my spiritual family throughout the world, for constant love, positivity and guidance to the truth.

To the women resident at the centre, you are special. May Allah be with you throughout your journey, and may you be blessed with love.

To my dear husband, Saleem, for your endearing support and sense of humour I am grateful.

My Supervisor, Professor Rosemary Crouch, for seeing this to fruition, and for your belief.

To my editor, Carrin Martin for her patience and ability to transform.

My dear colleagues, Debbie Fewster and Fatima Seedat for your guidance.

To the Board and staff at the Women's Centre, thank you for your special warmth and commitment to the process of assisting vulnerable women.

TABLE OF CONTENTS

SUPERVISORS PERMISSION TO SUBMIT	i
DECLARATION	ii
DEDICATION	iii
ACKNOWLEDGEMENTS	iv
LIST OF TABLES	x
LIST OF FIGURES	xi
OPERATIONAL DEFINITIONS	xii
ABBREVIATIONS	xiv
ABSTRACT	xv

CHAPTER ONE

INTRODUCTION

1.1	INTRODUCTION	1
1.2	BACKGROUND	2
1.3	SPIRITUALITY, ABUSE AND OCCUPATIONAL THERAPY	4
1.4	PROBLEM STATEMENT	5
1.5	RESEARCH QUESTION	6
1.6	AIMS AND OBJECTIVES	6
1.7	TYPE OF STUDY AND METHOD	7
1.8	OUTLINE OF STUDY	7
1.9	STATEMENT OF REFLEXIVITY	8
1.10	CONCLUSION	10

CHAPTER TWO

LITERATURE REVIEW

2.1	INTRODUCTION	11
2.2	THEORETICAL FRAMEWORK	12

2.2.1	Canadian Model Of Human Occupation And Engagement	12
2.2.2	Meaning Making Coping Model	14
2.3	DEFINING SPIRITUALITY AND SPIRITUAL CONCEPTS IN THE LIGHT OF OCCUPATIONAL THERAPY GROUPWORK	16
2.3.1	Group Therapy Dynamics	16
2.3.2	Defining Spirituality	23
2.3.3	Defining Concepts Within Spirituality	25
2.4	ADDRESSING SPIRITUALITY IN OCCUPATIONAL THERAPY GROUPWORK WITH ABUSED AND VULNERABLE WOMEN	27
2.4.1	Spirituality In Occupational Therapy	27
2.4.2	Spirituality And Post Traumatic Coping	33
2.4.3	Programs Currently Addressing Spirituality In Healthcare	36
2.5	CONCLUSION	42

CHAPTER THREE

METHODOLOGY

3.1	INTRODUCTION	43
3.2	STUDY SETTING	43
3.3	STUDY SAMPLE	44
3.4	THE GROUP THERAPY PROGRAM	45
3.5	SPIRITUAL CONCEPTS ARISING IN GROUP THERAPY	50
3.6	RESEARCH DESIGN	51
3.7	DATA COLLECTION TOOLS	52
3.7.1	Semi Structured Interviews	52
3.7.2	The Interview Schedule	53
3.8	DATA COLLECTION	56
3.9	DATA ANALYSIS	57
3.9.1	Allocation of Pseudonyms	57

3.9.2	Content Areas	58
3.9.3	Coding	59
3.9.4	Themes	60
3.10	TRUSTWORTHINESS AND RIGOUR	60
3.10.1	Credibility	60
3.10.2	Dependability	62
3.10.3	Transferability	62
3.10.4	Reflexivity	63
3.10.5	Member Checking And Prolonged Engagement	63
3.11	ETHICAL CONSIDERATIONS	64
3.12	CONCLUSION	65

CHAPTER FOUR

FINDINGS

4.1	INTRODUCTION	66
4.2	PARTICIPANT PROFILES	68
4.2.1	Hawa	68
4.2.2	Maryam	69
4.2.3	Amina	70
4.2.4	Khadija	70
4.2.5	Fatima	71
4.2.6	Ayesha	71
4.2.7	Rabia	71
4.3	THEME A: TOWARDS AN UNDERSTANDING OF SPIRITUALITY...	72
4.3.1	A Connection	72
4.3.2	To Have Faith and Believe	73
4.3.3	A Source of Help	73

4.4	THEME B: RESOURCES AVAILABLE TO ADDRESS SPIRITUAL WELL-BEING	75
4.4.1	Group Therapy	75
4.4.2	Clergy	76
4.4.3	Other Community Resources	78
4.5	THEME C: ENHANCING MEANINGFUL SPIRITUAL PRACTICES	80
4.5.1	Rituals and Prayer	80
4.5.2	Breathing and Salaah	81
4.5.3	Perceptions about Religion	81
4.5.4	Strengthening Connection	82
4.6	THEME D: APPLYING SPIRITUAL CONCEPTS IN GROUP THERAPY	84
4.6.1	Anger and Forgiveness	85
4.6.2	Positive Thinking	86
4.6.3	Gratitude	87
4.7	CONCLUSION	88

CHAPTER FIVE

DISCUSSION

5.1	INTRODUCTION	89
5.2	THEORETICAL FRAMEWORK	89
5.3	THEME A: TOWARDS AN UNDERSTANDING OF SPIRITUALITY...	92
5.4	THEME B: RESOURCES AVAILABLE TO ADDRESS SPIRITUAL WELL-BEING	95
5.5	THEME C: ENHANCING MEANINGFUL SPIRITUAL PRACTISES	99
5.6	THEME D: APPLYING SPIRITUAL CONCEPTS IN GROUP THERAPY	104
5.7	CONCLUSION	107

CHAPTER SIX

CONCLUSION

6.1	INTRODUCTION	108
6.2	DISCUSSION	109
6.3	SIGNIFICANCE AND IMPLICATIONS OF THE STUDY	111
6.4	LIMITATIONS OF THE STUDY	112
6.5	RECOMMENDATIONS FROM THE STUDY	113
6.5.1	Curriculum Development	113
6.5.2	Treatment and Service Delivery	114
6.5.3	Health Promotion	115
6.6	CONCLUSION	116

REFERENCE LIST	117
-----------------------	------------

APPENDICES

1.a	Ethical Clearance Certificate	122
1.b	Letter of Amendment of Title	123
2.	Letter Requesting Permission to Conduct Study	124
3.	Gate-keepers Permission	126
4.	Invitation to Participate in Research	128
5.	Informed Consent	130
6.	Interview Schedule	132

LIST OF TABLES

Table 2.1:	Outline of sessions for Solace of the Soul Program	37
Table 3.1:	Inclusion and Exclusion Criteria	45
Table 3.2:	Attainment of Sample Size (n)	45
Table 3.3:	Structure of Interview Schedule	54
Table 3.4:	Example of Abstraction into Codes	59

LIST OF FIGURES

Figure 2.1:	A Diagrammatic Representation of the CMOP-E, Displaying Spirituality as central to occupation	13
Figure 2.2:	A Diagrammatic Representation of the MMCM	14
Figure 3.1:	Artwork by Group Members at the Women's centre	47
Figure 4.1:	Themes, Sub-themes and Categories	67
Figure 4.2:	Diagram Lining Themes to Objectives	68
Figure 4.3:	Theme A	72
Figure 4.4:	Theme B	75
Figure 4.5:	Theme C	80
Figure 4.6:	Theme D	85
Figure 5.1:	Theme A linked to Objective 1	92
Figure 5.2:	Theme B linked to Objective 2	95
Figure 5.3:	Theme C linked to Objectives 2 and 3	100
Figure 5.4:	Theme D linked to Objectives 2,3, and 4	105

OPERATIONAL DEFINITIONS

Abuse: *A behavioural pattern of physical or sexual assault, financial dependency, verbal insults, and spiritual or emotional coercion (Hassouneh-Phillips, 2003)*

Allah: *Name of God in Islam. Translated as 'One who is worthy of worship.' (Merriam-Webster, 2004; Pickthall, 1973)*

Clergy: *People (such as priests) who are the leaders of a religion and who perform religious services (Merriam-Webster, 2004)*

Culture: *The beliefs and perception, values and norms, and customs and behaviours that are shared by a group or society. (Kielhofner, 2007)*

Group dynamics: *The forces that influence the interrelationships of members and ultimately affect group outcome (Cole, 2012).*

Hadith: *A saying of Muhammad (Chittick, 2007)*

Health: *Health is not just the absence of disease; it is a state of physical, psychological, social and spiritual well-being (WHO, 2003)*

Occupation: *All goal directed engagement in self-care, work or leisure activities (AOTA, 2002)*

Occupational Performance: *The ability to choose, organise, and satisfactorily perform meaningful occupations that are culturally defined and age appropriate for looking after one's self, enjoying life and contributing to the social and economic fabric of a community. (AOTA, 2002)*

Quran: *The book of sacred writings used in the Muslim religion. The word of God revealed to Muhammad by means of angel Gabriel (Chittick, 2007; Merriam-Webster, 2004)*

Salaah: *The daily ritual prayer, the daily performance of which is the second pillar of Islam (Chittick, 2007).*

Spirituality: *Beliefs and practises through which people develop personal values, and their own beliefs about meaning and purpose in life (Hassouneh-Phillips, 2003)*

Spirituality: *A pervasive life force, manifestation of a higher self, source of will and determination, and a sense of meaning, purpose and connectedness that people experience in the context of their environment (Unruh, Versnel, & Kerr, 2002).*

Vulnerable: *Easily hurt or harmed physically, mentally, or emotionally; open to attack, harm, or damage (Merriam-Webster, 2004)*

Zikr: *Reminder, remembrance. Methodological repetition of one of the names of Allah. Similar to Hindu mantra (Chittick, 2007)*

ABBREVIATIONS

CMOP-E: *Canadian Model of Occupational Function and Engagement*

MMCM: *Meaning Making Coping Model*

ABSTRACT:

Spirituality has gained recognition as a vital factor in mental healthcare, and has been applied to major occupational therapy models. However, its clinical application is limited universally, to the possible detriment of patients. This phenomenological study aimed to explore the experiences of abused and vulnerable Muslim women on addressing spirituality in occupational therapy groupwork, including understanding a definition of spirituality, and avenues to address spirituality. An in-patient Women's centre with a spiritual ethos was identified, where patients were exposed to a series of occupational therapy groups including concepts of spirituality. Semi-structured individual interviews were conducted on 7 purposively selected participants, and followed by thematic analysis. The findings reflected through the emergence of 4 themes that addressing spirituality conforms with client-centeredness, and enhanced a sense of meaning and purpose for the participants. Strength and motivation was drawn from applying spiritual concepts in group therapy sessions, ultimately facilitating better coping and empowerment, which reflected in their daily occupation. Implications of this study extend to curriculum development, treatment and service delivery, and health promotion.

Keywords: Occupational therapy, group therapy, spirituality, abused women, CMOPE-E, Meaning making coping model

CHAPTER 1. INTRODUCTION

1.1 INTRODUCTION

Islam has given all women independence, rights, respect and a high status in society (Dangor, 2001; Douki, Nacef, Belhadj, Bouasker, & Ghachem, 2003; Pickthall, 1973), and has prescribed through the Quran, a lifestyle which protects society against abusive relationships (Pickthall, 1973). The 1996 constitution of South Africa protects the rights of women, ensuring equal status in law and protection from all forms of abuse (Constitution, 2011). However, despite these legal and cultural mechanisms to protect women, abuse continues to rise, including within followers of Islam (Dangor, 2001; Hassouneh-Phillips, 2003; Ibrahim & Abdalla, 2010).

Hassouneh-Phillips (2003) examined the role of spirituality in abused American Muslim women's lives, and defined spirituality in the same article as beliefs and practises through which people develop personal values, and their own beliefs about meaning and purpose in life. In the absence of a standard definition, many definitions are offered, which all capture the essential elements of affording individuals a sense of meaning and purpose and impacting on their value system, but may or may not assert a connection to a higher being (Unruh, Versnel, & Kerr, 2002). Spirituality plays a vital role in addressing the therapeutic needs of women and many other vulnerable groups, yet its practise is lacking, both in occupational therapy and group therapy scenarios (Cornish & Wade, 2010; Hassouneh-Phillips, 2003; Hess & Ramugondo, 2014).

This chapter presents a background to the study, including perspectives on abuse in the Muslim community in Durban, South Africa, and the application of spirituality within occupational therapy and mental healthcare. The problem statement, research question, aims and objectives will be outlined, followed by an outline of the following chapters, and a statement of reflexivity.

1.2 BACKGROUND

Women across the globe are subjected to abuse in many forms (Dangor, 2001; Douki, Nacef, Belhadj, Bouasker, & Ghachem, 2003; Padayachee & Singh, 2003; Singh, 2013). Ibrahim and Abdalla (2010) define domestic violence as one family member exerting control over another and states that the most common type of abuse is male partner abuse against females. Abuse is recognised as a behavioural pattern of physical or sexual assault, financial dependency, verbal insults, and spiritual or emotional coercion (Hassouneh-Phillips, 2003; Ibrahim & Abdalla, 2010). Consequences of this affliction cost the economy billions each year in associated health, psychological, neurological and social costs, and affect child and societal development (Nordien, Alpaslan, & Pretorius, 2003; Oosthuizen & Wissing, 2005).

A recent study conducted in Egypt, Palestine, Israel and Tunisia reports that one third of Muslim women have been abused during marriage and pregnancy (Douki et al., 2003). A study on South Asian Muslim women in North America indicated that 24% of women who screened positive for domestic violence experienced physical abuse (Ibrahim & Abdalla, 2010).

Domestic violence is prevalent in all socioeconomic backgrounds in South Africa (Gibson-McCrary & Upchurch, 2015). South Africa's rural community of North West province, 62% of women reported experiencing violence, while 42% of women reported experiencing violence regularly (Oosthuizen & Wissing, 2005). 35% of women admitted to the ante-natal department at Durban's King Edward VIII Hospital were victims of domestic abuse during their pregnancy (Mbokota & Moodley, 2003). The average South African woman will remain in an abusive relationship for ten years before taking any action (Singh, 2013).

Both in and out-patient community funded centres, which generally lack resources and professional staff, have been established in Durban, South Africa, where this population of women are offered respite. Social workers at three such centres for abused and vulnerable women agree that statistics on abuse are skewed (Singh, 2013), mainly due to a lack of reporting and the negative stigma attached to abusive households (Alers, 2010; Oosthuizen & Wissing, 2005). Statistics from the Advice Desk for Abused Women reveal that 8050 calls were received during the period

2009 – 2011, of which 825 (8.84 %) calls were from Muslim households (Singh, 2013).

Religious teachings of Islam are not always synonymous with cultural values lived by Muslims in the present day (Hassouneh-Phillips, 2003). Based on a misunderstanding of fundamental principles, Islam is commonly portrayed to the general public as a religion condoning wife abuse, (Ibrahim & Abdalla, 2010; Nordien et al., 2003). The same article then quotes many references where kindness and love towards the wife are strongly advocated, and abuse, intolerance and harshness are warned against.

“In the Qur’anic paradigm, however, marriage is represented as a means of tranquillity, protection, encouragement, peace, kindness, comfort, justice, mercy, and love (Qur’an, 2:187 & 229-237; 4:19 & 25; 9:71; 30:21).”(Ibrahim & Abdalla, 2010 page 10)

After prescribing methods of reconciliation, the Quran allows divorce in cases of severe marital discord. Central to the process of divorce, is the kind and merciful treatment of the woman throughout, emphasising that He (Allah) is the ultimate source of help and sustenance to both parties (Pickthall, 1973).

Efforts to discard spirituality from the field of psychotherapy were pioneered by Sigmund Freud almost 80 years ago (Carone Jr & Barone, 2001; Webb, Toussaint, & Conway-Williams, 2012). Since then, Pastors, Moulanas, Guru’s, Traditional Healers and other religious and spiritual mentors were considered the consultative source on matters of forgiveness, grieving, trauma, and depression. Until a renewed interest in the concept of spirituality within mental health care a mere 15 years ago (Unruh et al., 2002), spirituality was reserved for the confines of ritualistic worship, with less focus on incorporating it within a holistic lifestyle.

The World Health Organisation has amended the definition of health to include spirituality as follows: “Health is not just the absence of disease; it is a state of physical, psychological, social and spiritual well-being” (WHO, 2003). The Diagnostic and Statistical Manual of Mental Disorders – Text Revision (DSM IV- TR) was amended in 2003, making allowance for religious or spiritual issues arising

during psychiatric assessment as an “additional condition that may be the focus of clinical attention”, noted on Axis 1.

Research has documented positive effects, both direct and indirect, of addressing spirituality in reducing the perpetration of abuse (Hassouneh-Phillips, 2003; Ibrahim & Abdalla, 2010; Murray-Swank & Pargament, 2005), with a growing number of religious leaders offering victims respite in the way of awareness, support and spiritual guidance (Singh, 2013). However, addressing spirituality in occupational therapy groupwork remains an under-explored field.

1.3 SPIRITUALITY, ABUSE AND OCCUPATIONAL THERAPY GROUPWORK

Spirituality, religion and culture are terms whose meanings are intricately intertwined. A clear delineation of the boundary between spirituality and religion does exist, but may be difficult to maintain within a practical and therapeutic setting (George, Larson, Koenig, & McCullough, 2000). The terms are often used interchangeably without sensitivity to a mixed audience, and religion is almost always the first aspect to be recognised (Wilding, 2002). Religious participation however, does not necessarily include a spiritual component, and vice versa (George et al., 2000). Shaw, Joseph, and Linley (2005) use the terms interchangeably, due mainly to the paucity of research defining spirituality, as well as the difficulty in meaningfully untangling the concepts.

Culture is defined as the beliefs and perceptions, values and norms, and customs and behaviours that are shared by a group or society (Kielhofner, 2007). Culture also greatly influences what people believe about the causes of illness and recovery (Sherry, 2010). Culture is therefore part and parcel of one’s spiritual identity. In designing a treatment program comprising of meaningful activities, an occupational therapist is compelled to consider observable cultural behaviour, as well as have an understanding of cultural rules pertaining to that behaviour (R Crouch, 2010). For the purposes of this study, the terms religion and culture will be considered under the same blanket term of spirituality.

Women who experienced violence regularly experienced lower quality of life in work, play, love, family, home and community domains (Oosthuizen & Wissing, 2005),

necessitating occupational therapy's active role in rehabilitating abused and vulnerable women, which is defined as empowerment to recognise one's own potential through meaningful occupation (Simó-Algado, Mehta, Kronenberg, Cockburn, & Kirsh, 2002). This definition speaks to the heart of spirituality through its reference to meaningful occupation. Post-traumatic growth asserts that the potential for growth and change exists within the depths of trauma, and a victim's spiritual disposition would impact on this potential growth and meaningful occupation (Ebadi, Ahmadi, Ghanei, & Kazemnejad, 2009; Shaw et al., 2005).

Within the field of occupational therapy, progressive academics have amended models, including the Canadian Model of Occupational Performance, to incorporate spirituality as central to a person's global functioning. However, studies suggest that spirituality is not being applied in practise. Other studies highlight that spirituality is inherent in the practise of occupational therapy, through its essential definition and goals, the therapist's attitude and client-centeredness (Teo, 2009).

Group therapy has shown to be effective in facilitating change on all levels of occupational performance (Bermudez et al., 2013; Polatajko, Townsend, & Craik, 2007; Wegner, Caldwell, & Smith, 2014) and is a cost effective medium to address the scourge of abuse in the Muslim community.

1.4 PROBLEM STATEMENT

Although major theorists in the field of occupational therapy have defined spirituality, the absence of a universal and standard definition of spirituality remains a key cause for the lack of practical application in the field of healthcare. Vast cultural and demographic differences render it difficult to create a universally acceptable definition, whilst universally applicable definitions seem to lack a meaningful specificity. An understanding of spirituality specific to a core group of participants is therefore required in order to progress with the discussion of spirituality within the safety net of group therapy. This study thus aims to define spirituality from the perspective of abused and vulnerable Muslim women.

Given the current statistics and lack of resources, group therapy with abused and vulnerable Muslim women in Durban, South Africa provides a cost effective space

for participants to connect, facilitating deep conversation (Cornish & Wade, 2010). With awareness of abuse in the community growing and facilities springing up, addressing spirituality in occupational therapy groupwork at these centres could become an essential and effective treatment approach.

Although spirituality is found to be used as a coping strategy following abusive circumstances (Oosthuizen & Wissing, 2005), studies addressing the practical application of spirituality within group therapy have not yet been done (Cornish & Wade, 2010). In the absence of this evidence, it would appear that Muslim women experiencing abusive relationships, have not been afforded the opportunity to address spirituality in a group therapy context. This is contrary to the literature that supports the client-centeredness spirituality. This study seeks to understand the phenomenon of addressing spirituality in group therapy with abused and vulnerable Muslim women, and the implications for clinical practise.

1.5 RESEARCH QUESTION

What are the experiences of abused and vulnerable Muslim women regarding the role of addressing spirituality within their group therapy process?

1.6 AIMS AND OBJECTIVES

The aim of the study was to explore how addressing spirituality could facilitate and positively enhance the occupational therapy group dynamic for abused and vulnerable Muslim women receiving treatment at a Women's Centre.

Objectives of the study:

1. To explore a definition of spirituality for abused and vulnerable Muslim Women;
2. To establish the scope of occupational therapy group practise within the Muslim faith;
3. To explore abused and vulnerable Muslim women's experiences of spirituality as a coping strategy;

4. To explore abused and vulnerable Muslim women's experiences of including spiritual constructs, in a group therapy program.

1.7 TYPE OF STUDY AND METHOD

A phenomenological study was undertaken at a shelter for abused and vulnerable women. The study commenced after a programme of group therapy including spiritual concepts was facilitated by an occupational therapist. Participants were selected according to inclusion and exclusion criteria for the study, and interviewed regarding their experiences of addressing spirituality within a group therapy programme. An interview schedule was designed to explore their experiences. Interviews were recorded and transcribed verbatim, before being thematically analysed. Findings were documented and discussed relating to the literature, in a format consistent with a phenomenological study.

1.8 OUTLINE OF STUDY

This phenomenological study will include the following salient points in the chapters that follow:

- Chapter 2: A literature review will comprise of a theoretical framework, including 2 theories applicable to the fields of spirituality and post traumatic coping. Definitions of group dynamics, spirituality and related concepts will follow. Opportunities and perceived barriers to practising spirituality within occupational therapy, and current programmes within mental health care designed to address spirituality, will precede the conclusion.
- Chapter 3: Methodology will be explained, including the study setting and highlights of the programme that was offered prior to the research. Research design, sampling, data gathering techniques, procedure, data analysis and ethical considerations will be noted in this chapter.
- Chapter 4: A brief profile of the participants will begin this chapter. Findings will then be presented as themes including relevant quotations. Graphic representations will demonstrate the emergent themes and their link to the objectives, and quotations will be used to illustrate each theme. In keeping

with phenomenology, textural (what was experienced?) and structural (how was it experienced?) descriptions, will precede an effort to capture the essence of the experience.

- Chapter 5: The discussion chapter will be introduced by revisiting the research question. The theoretical frameworks will be applied to the findings, followed by a discussion on each theme. The discussion will link the theme with relevant objectives, and the literature reviewed in chapter 2.
- Chapter 6: Closing thoughts, implications, limitations and recommendations of the study are outlined. References are located at the end of this chapter, and appendices will include the ethical clearance certificate and amendment of title letter, gatekeeper's correspondence, information to participants, consent to interview forms, and interview schedule.

1.9 STATEMENT OF REFLEXIVITY

A phenomenological study requires that the researcher bracket themselves from the research, by expressing their involvement in the phenomenon at the outset. This exercise serves to limit reactivity bias throughout the research process (Creswell, 2012).

The researcher of this study is of South African Indian origin, and was born into Islamic faith. Cultural viewpoints littered Islamic religious practises at the time, and the researcher witnessed the undermining of the female opinion and feelings, whilst authoritarianism marred domestic life, in what was a male dominated view of Islamic teachings. She witnessed ritualistic following of Islam void of love, peace and balance. Marital discord seldom ended in divorce, as a matter of pride on the part of the male, while the females were faced with a lack of education, financial support and well-being of the children. This background demanded that during this research paper the researcher was aware of possible over-identifying and being vicariously traumatised by the participants.

Through a process of understanding her spirituality, the researcher learned that women held a high status in Islam, and that in order to build powerful and positive

relationships, compassion, acceptance and tolerance should underlie the treatment of women. She also learned to balance her view of the Muslim male. She hoped that through exploring their spirituality, the participants of this research project would gain insights that changed their view of themselves. Negative experiences of addressing spirituality among participants may also occur, and should be examined.

The researcher is also the group therapist in this research project, and this dynamic has both advantages and disadvantages. Due to the researcher's prolonged engagement, the participants would have open communication and be comfortable enough to share any negative opinions. However, there is potential for the Hawthorne effect (Leonard & Masatu, 2006), whereby participants may choose to respond in a manner that is pleasing to the researcher. To counteract this power dynamic, it will be made clear that any negative criticism would be welcomed and honesty would enhance this project. Probes asking if participants felt vulnerable or intimidated, or had any negative feedback on the group sessions have also been included.

Spirituality is a personal choice and a unique journey, which needs to be recognised and acknowledged within both therapists and clients. During this process of exploring spirituality in group therapy, the researcher's expression of spirituality should not be imposed on any participant with a differing viewpoint. Similarly, as the facilitator, she should be aware of an imposition of any group participant's ideas.

During the researcher's career as a group therapist, as well as leading a youth club, it was glaring that group activity had a mobilising effect on the group. Addressing spirituality in a group, as opposed to individually, can accelerate the positive effects on coping, empowerment and motivation as noted in the literature. However, participants must be allowed to express individuality and develop at a pace suitable for them. Some resistance may be directed to the group therapy dynamic, or towards addressing spirituality, and this resistance should be respected.

In considering spirituality within group therapy, conducting rituals and prayers are known to have a profound effect on the group dynamic. Having the therapist and participants share the same faith in this research project, would make fertile ground

for the use of rituals and prayers as part of the group dynamic. However, any ritual should be initiated and conducted by the group, and anyone wishing to decline the invitation to the ritual or prayer should be respected.

1.10 CONCLUSION

Muslim women are included in the growing statistics of abused and vulnerable women globally. Facilities have recently been established in Durban, South Africa, where abused and vulnerable women can be removed from the abusive environment and offered respite, including a spiritual environment. Occupational therapy groups have a role to play in re-integrating these women into society as empowered women with healthy coping mechanisms. Spirituality is an essential element of coping post trauma, and is shown to be effective in creating a healthy and evolved state of mental well-being. This paper will examine the experience of spirituality as part of occupational therapy groups with abused and vulnerable Muslim women in Durban, South Africa, and conclude with recommendations for the application of spirituality in occupational therapy groups.

CHAPTER 2. LITERATURE REVIEW

2.1 INTRODUCTION

This chapter will review the Canadian Model of Occupational Performance and Engagement (CMOP-E) (Polatajko et al., 2007) and the Meaning Making Coping Model (MMCM) (Park 2005) as the theoretical framework for this study. Both models have been the subject of much research in the fields of occupational therapy and mental health care.

Furthermore, this chapter will expand on group dynamics, current definitions of spirituality and spiritual concepts, and the need for a standardised operational definition. A definition for the purposes of this study will be suggested. An overview of the development of the concept of spirituality within the fields of occupational therapy, abused and vulnerable women, and group therapy will follow.

The literature review was conducted using search engines SABINET, PUBMED and Google Scholar. Among the domains used were the theories applied, spirituality in occupational therapy, spirituality in mental healthcare, abused women in occupational therapy groups, abused women in Durban, occupational therapy group work, CMOP-E and abused women, MMCM and abused women, phenomenological studies with abused women. Various books on group therapy in Occupational therapy were consulted. In addition, the following documents were searched:

- AOTA Occupational Therapy Practise Framework
- Canadian Occupational Therapy
- WHO Definition of health
- Constitution of South Africa
- Translation of the Quraan.
- DSM IV TR

A total of approximately one hundred articles, books and documents were consulted. No literature was found relating to occupational therapy groupwork with abused women,

2.2 THEORETICAL FRAMEWORK

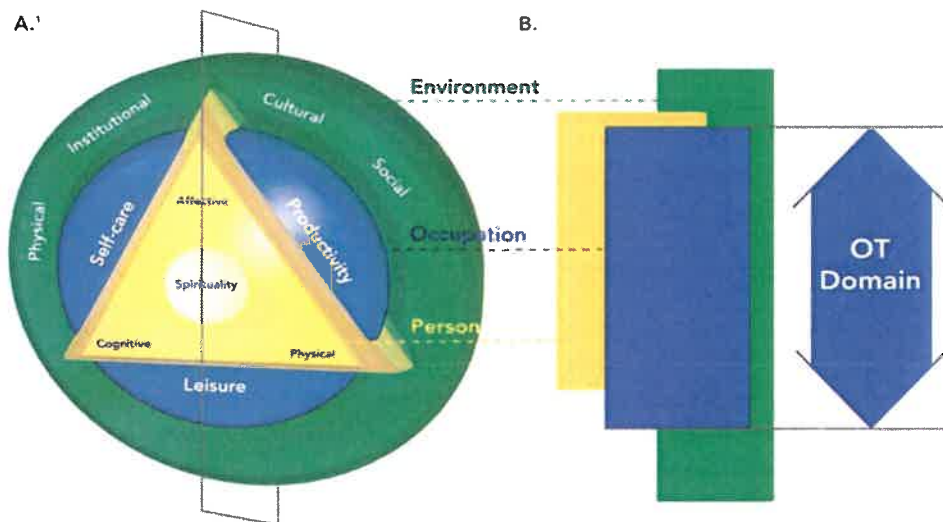
Two models will be applied to this research. The CMOP-E (Polatajko et al., 2007) is applied due to the emphasis on spirituality as the core of human occupation. The MMCM (Park, 2005) is applied as post traumatic coping is an important aim of treatment with abused and vulnerable women.

2.2.1 Canadian Model Of Occupational Performance And Engagement (CMOP-E)

CMOP-E (Polatajko et al., 2007) defines occupational performance as follows: “The ability to choose, organise, and satisfactorily perform meaningful occupations that are culturally defined and age appropriate for looking after one’s self, enjoying life and contributing to the social and economic fabric of a community.” The model further states that occupational performance is a result of a dynamic and interdependent relationship between persons, environment and occupation over a person’s lifespan, and that change in any aspect of the relationship will affect occupation (Polatajko et al., 2007).

Spirituality is defined in the CMOP-E as a pervasive life force, manifestation of a higher self, source of will and determination, and a sense of meaning, purpose and connectedness that people experience in the context of their environment (Unruh et al., 2002; Wong & Fisher, 2015). Figure 2.1 shows that spirituality is placed at the centre of the model, implying a deeply embedded core in all parts of the person, environment and occupation interaction. Spirituality is also shaped by the environment, and gives meaning to occupations.

This model highlights client-centeredness, which is amongst the fundamental philosophies of occupational therapy (Cole, 2012; Wong & Fisher, 2015). Spirituality, being the core of occupational performance according to the CMOP-E, is therefore an essential humanistic consideration to client-centeredness (Cole, 2012). One way that it can be translated into practise is by setting meaningful occupational goals with the client.



A. Referred to as the CMOP in *Enabling Occupation* (1997a, 2002) and CMOP-E as of this edition
B. Trans-sectional view

Polatajko, H. J., Townsend, E. A., Craik, J. (2007). *Canadian Model of Occupational Performance and Engagement (CMOP-E)*. In E. A. Townsend and H. J. Polatajko, *Enabling Occupation II: Advancing an Occupational Therapy Vision of Health, Well-being, & Justice through Occupation*. p.23 Ottawa, ON: CAOT Publications ACE.

Figure 2.1: A Diagrammatic Representation of the CMOP-E, Displaying Spirituality's Centrality to Occupation (Polatajko et al., 2007)

The domain of occupational therapy practise lies primarily in self-care, productivity and leisure, although a comprehensive and client centred approach demands that the occupational therapy program address social change by impacting on social inequities and occupational disparities (Wong & Fisher, 2015). The model encourages the incorporation of institutional, cultural and environmental factors into a plan of treatment. Applying the model requires identifying a gap between desired and actual occupational participation, client feedback and advocating social justice (Wong & Fisher, 2015).

A study seeking to understand the role of occupational therapy in facilitating a school-based leisure programs (Wegner et al., 2014) applied the model by facilitating school-community partnerships (environmental level) and facilitating school based leisure programs (occupational performance level) of its population of school learners, in order to improve personal health and functioning of the community. The study confirms occupational therapy's role in impacting change on

environments, including policy development, where larger populations of people and greater societal needs can be addressed.

The study did not expound the role of spirituality on the population and the program administered, or vice versa. Inherently, the program sought to address spirituality through enabling learners to make meaningful choices for the well-being of the society. This aspect may be addressed in a future study.

2.2.2 The Meaning Making Coping Model

The MMCM (Park, 2005) is a model on coping post trauma, which was developed through integrating various coping and meaning theories. The premise is that individuals create a global meaning of an event (the abusive environment), based on global beliefs and goals. Global beliefs are the basic internal cognitive structures that guide and influence the construction of one's reality. Spirituality would be a prime factor in the establishment of a global belief system. Global goals are basic internal representations of desired outcomes that motivate individuals.

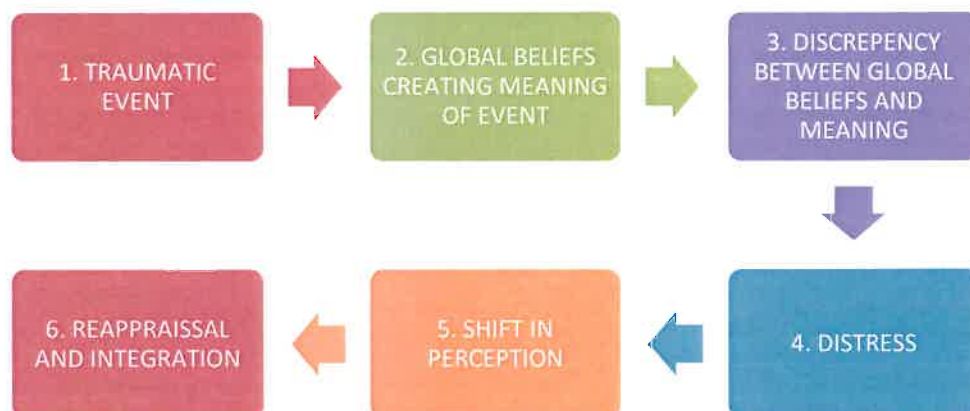


Figure 2.2

Diagrammatic Representation Of The Meaning Making Coping Model (Park, 2005)

As graphically represented in Figure 2.2, the model asserts a 6 step process of meaning making and coping for the traumatised victim. Following a traumatic event, an appraised meaning of the event is formulated, which generates answers to why the event occurred, decisions about what can be done to cope with the event, and whether it can be viewed as a loss, threat or challenge. This appraised meaning is either in line with the global meaning system, or oppositional. The extent to which the appraised meaning is discrepant with one's global meaning of the event is also

considered during an appraisal of an event. Should a discrepancy exist between the global meaning and appraised meaning of the event, distress will be created in varying degrees.

Throughout this dynamic process of meaning-making, spiritual beliefs influence the individuals appraised meanings of the traumatic event. Spirituality also helps to integrate appraised with global meaning systems and is more likely to be used in coping when it is a highly salient aspect of one's global meaning system (Park, 2005).

In order to reduce distress, an individual must shift their perception by revising their global beliefs and goals to accommodate this new information, thereby forming a reappraisal of the event, and then integrating the reappraisal with their global meaning system (Park, 2005). Group therapy combining spiritual and occupational therapy principles of treatment plays a vital role in facilitating this process of perception shift and change through integrating the new information, thus informing the process of coping.

It must be noted that spirituality may have a negative impact on the individual experiencing the trauma at the initial stages of coping, due to high levels of distress and huge discrepancies between global and re-appraised meanings. Spiritual disconnection, anger at and negative images of God have been reported as consequences of traumatic events (Murray-Swank & Pargament, 2005; Park, 2005). However, in the long term the converse is true (Park, 2005), where a positive sense of spirituality yields better coping.

A qualitative study to explore Muslim women's experiences of domestic violence in the Nelson Mandela Metropole, South Africa (Nordien et al., 2003) confirmed that religious practise, faith in God and prayer were sources of strength when either choosing to remain or leave an abusive relationship. Participants shifted perception to reduce their distress levels, through keeping themselves occupied, focussing on their relationships with their children, finding inner strength and retaliating. No therapeutic intervention was employed to create shifts in perception in this study.

2.3 DEFINING SPIRITUALITY AND SPIRITUAL CONCEPTS IN THE LIGHT OF OCCUPATIONAL THERAPY GROUPWORK

Creating a backdrop of group therapy dynamics and evidence based practise, will provide a clearer understanding of how this medium is richly suited to the field of spirituality, particularly with abused and vulnerable Muslim women. Although much research has been documented regarding the definition of spirituality, a standardised definition within mental health care is yet to be formulated. Section 2.3.2 will discuss the definitions, and an operational definition of spirituality for the purposes of this study will be formulated. Concepts within spirituality that are specific to this study will be defined according to the literature.

2.3.1 Group Therapy Dynamics

Group dynamics are defined as forces that influence the interrelationships of members and ultimately affect group outcome (Cole, 2012). Many factors affect group dynamics, including group process, norms and roles, and problematic behaviours. The group process is experienced through interactions with participants, and then examined by the group to extract and apply the lessons learned into the here and now (Cole, 2012).

a. Yalom's therapeutic factors (Yalom, 2005)

Yalom (2005) describes interdependent therapeutic factors which act as the agents of change, impacting on cognition, behaviour, emotions, or simply creating preconditions for change in group participants. The factors most salient for occupational therapy groups with abused and vulnerable women will be discussed below:

- **Installation of hope:** During the pre-group orientation, Yalom emphasises the need for the therapist to create positive expectations of help as an expression of hope. Hope may also be derived through observing change and improvements in other group participants. Hope to regain a balanced life, and to be 'ok' again, along with faith and belief, is a vital spiritual consideration in groupwork with abused and vulnerable Muslim women.
- **Universality:** The realisation through interaction that they are not alone. For the abused woman sharing intimate details of the incident brings much relief and healing from singly carrying their burdens of shame, guilt, stigma and

self-blame (Bermudez et al., 2013). Catharsis often occurs through this sharing.

- Imparting information: Therapists may impart didactic instruction in the form of psychoeducation, active coping skills or an activity. This information has an initial binding force in the group. Direct advice from group participants is a reality of group therapy, and implies mutual interest and caring. It may also be a measurement of resistance to intimate engagement during the early stages of the group.
- Interpersonal relationships: Yalom asserts that a diagnosis in mental health should be broken down into factors that can be changed, and interpersonal relationships is of primary importance. Past relationships with family, current relationships with perpetrators of abuse, children and friends, and establishing trust in future relationships need to be explored in group therapy, as they may be a primary contributor to the diagnosis. Occupational therapy groups have a role to play in facilitating change from passive or aggressive, to assertive communication. Feedback from other participants also facilitates change in interpersonal relationships.
- Existential factors: Reflection on life purpose is a natural progression with abused and vulnerable Muslim women. Group participants should arrive, through group therapy, to a position of control, motivation and self-esteem in assuming ultimate responsibility for the conduct of their lives, with strength from a Higher Power by their side. Yalom also describes mindfulness of being as an important factor in facilitating change from victim to survivor.

b. Group leadership roles (Cole, 2012)

A seven-step format indicates the group leadership roles in occupational therapy:

- Introduction: The group leader is responsible for ensuring that the setting is appropriate and accessible, and the atmosphere is warm. The leader introduces her name, title, and type of group. The participants are then given the opportunity to introduce themselves. A warm up exercise follows, which relaxes, and captures the attention of the participants, and prepares them for the exercise to follow. It also gives the therapist an indication of alertness and social skills of the

participants. The leader then sets down expectations of the group, and explains the purpose and outline of the group clearly. The introduction may vary during subsequent group sessions.

- Activity: An activity should be carefully selected using clinical reasoning. The activity must be compatible with the available materials, environment and time frame. Therapeutic goals and individual capacities of the participants must be carefully considered. The leader must be well acquainted with and have a flair for the activity, and the activity should be adapted or graded to suit participants needs.
- Sharing: On completion of the activity, the leader invites participants to share their experiences. There may be tangible finished products to share and discuss or insights learned and reflected on. All participants should share and be validated by the group.
- Processing: Group process dictates that the experiences of group therapy must be learned through reflection. Participants are now invited to reflect on lessons learned during the session. Positive and negative feedback should be encouraged, as through negative feedback change and learning can take place. Asking the question “what did that mean for you?” is a useful way of stimulating the discussion.
- Generalising: The leader has the task of gathering the most pertinent issues raised during processing, and present them to the group as lessons to be learned. Group participants should be offered to add anything to the insights learned.
- Application: This stage requires that lessons learned during sharing, processing and generalising are applied to the participant’s everyday lifestyle. Thus a skill is learned by the participants and can be applied for time to come. A useful question to put forward to the group is “how are we going to live that in everyday life?” The group can be invited to write down reflections on the application of lessons learned.
- Summary: The last 5 minutes of the group should highlight the important aspects of the group, from the introduction to the summary.

Emotional content should also be summarised. The leader may also ask the participants to highlight salient features of the session. The group should be timeously concluded by acknowledging the participants, and thanking them for their engagement.

In addition to fulfilling the above mentioned roles, the leader is also responsible for motivating the group participants, as encouragement to interact and be enthusiastic is essential for participation, learning and change to occur. By the leader taking a confident stance and controlling the group from the introduction phase, the group's interest and motivation are peaked.

The group leader is responsible for finding the balance between being authoritative and allowing free expression from the group. A few rules may need to be set during the introduction, in collaboration with the participants, and with much respect. Confidentiality must be enforced as a rule, and cellular telephones should be switched off. Allowing sufficient time for participants to contribute, without a few participants dominating the session needs to be affirmed. Inappropriate behaviour, for example vulgar language, must be interrupted and curbed, and the group brought back to its process.

c. Stages of group development (Yalom, 2005)

Yalom further postulates that group dynamics develop in stages from orientation to conflict, and eventually to cohesive maturity. **Orientation** includes a pre-group interview where collaborative goals are set, group participation is discussed, and any anxieties allayed. Initially the group requires structure in terms of rules, contracts, and norms for the group.

As participants become more comfortable and familiar with the group dynamics, power issues begin to surface. During the **conflict** stage, participants may begin to complain or rebel against the group process, the leadership style or the group structure. The facilitator should then bring awareness to the conflict and allow the group to process.

Cohesive maturity occurs as the stage following the conflict resolution, and is characterised by a high morale and mutual support. Intimacy and trust replaces power issues and rebellion, and both positive and negative expressions flow freely (Yalom, 2005).

d. Phases of a task-centered occupational therapy group (Cole, 2012)

Occupational therapy groups also apply the above mentioned principles of group therapy, with a specific focus on meaningful activity. A task-centered group requires **planning**, where the group participants may be involved in brainstorming ideas for the activity and discussion about which opinion is preferred. A decision should be made by the group, followed by specific planning for materials, venue, times, and procedure. Division of labour should be done by the group members, and overseen to be fair and appropriate.

The **doing** phase of the group is primarily the task of the group members, with the facilitator serving a consultative, advisory and informative role. The facilitator is also responsible for bringing forth problems that occurred during the group, and allowing the group to resolve them.

Although a task-centered group may occur over a period of sessions, the **evaluation** phase of the group should occur at the end of every session. The facilitator reserves time for evaluation, and calls the group to start concluding. Evaluation should focus on the group process and each participant's role. Experiences, feelings and accomplishment of goals should be reflected on by asking relevant questions.

e. Problematic behaviour in group therapy

Problematic behaviour in group therapy can hinder the group dynamics and integrity of the group. It is important for the facilitator to recognise and understand the participant's behaviour and engage the group in empathy.

- The **monopolist** is the member who has aggressive communication style and rebels the group process. A need to control and monopolise the group should be counteracted by allowing the group to assertively express their feelings towards the monopoliser's behaviour. (Cole, 2012).

- The **silent** member can go unnoticed during the initial stages of the group therapy progression. During the conflict stage, group participants might insist on knowing what the silent member is thinking. Silent members might feel inadequate, out of tune with the others, or fearful of self-disclosure. The silent member should be allowed a forum to express their issues, and their silence should thereafter be respected. The facilitator should also try to find more common ground where the member feels like engaging (Cole, 2012)
- **Attention-seeking** behaviours may reflect a low self-esteem and a need for acknowledgement. The self-deprecator is constantly bringing themselves down, and are not open to healing thoughts and opinions from the group. The help-rejecting complainer constantly rejects the help they ask the group for, generally responding with “yes, but”. The narcissistic member demand constant and undivided attention of the group, feeling entitled to concern, compliments, and yet gives none to others. All the attention seeking behaviours benefit from empathy, and kind feedback through the group process. The only resolution is for the participant to recognise and understand their behaviour through the group process, in order to change (Cole, 2012).

b. Evidence for group therapy with abused and vulnerable women

Studies on occupational therapy groups with abused and vulnerable women are scant. The studies related below bear testimony to the efficacy of group therapy with abused and vulnerable women, and other vulnerable populations.

A longitudinal study of community dwelling older adults following a series of occupational therapy groups revealed that the participants felt a sense of validation from their peer group, broke down their isolation practised new skills in a safe environment, and builds social support and friendships (Craig & Mountain, 2007). They also reported generating ideas through listening to each other, engaging in group problem solving, and learning through modelling from other participants. The authors attributed increased self-efficacy in the participants to doing activities with others and translating skills learned into real world experiences (Cole, 2012).

In a study comparing the effectiveness of individual with both individual and group therapy treatments in battered women in a community setting (Echeburúa, Sarasua, & Zubizarreta, 2013), it was found that the latter was as effective, but produced better sustained effectiveness over a period of 1 year. Participants reported better coping with emotional discomfort and improved functioning in everyday life, when the abusive partner was removed, than the control group.

Addressing spirituality strengthens group dynamics which allows for conversation among participants that may not be socially appropriate in other settings. Strengthened group dynamics facilitate more effective outcomes of group therapy (Cornish & Wade, 2010). Further, through imitative behaviour (Yalom, 2005), group participants may become aware of and apply the strength and resilience bearing features of spirituality, as discussed by other participants (Cornish & Wade, 2010).

A mindfulness group with women who experienced intimate partner violence reported that the universality of the group promoted their healing from the trauma (Bermudez et al., 2013). The mindfulness group setting helped the women to discuss and process the trauma at their own pace, without the instructor needing to directly address it.

On a macro level, occupational therapy groupwork has a role to play in attending to the social injustices leading to vulnerable populations (Wong & Fisher, 2015). Wegner et al. (2014) facilitated networks between community resources and schools, in order to improve occupational performance of learners in the area of leisure pursuits. The success of this program was attributed to the role of occupational therapists as youth development officers.

Occupational therapy groupwork as a means of addressing vulnerable populations offers not only a cost effective approach, but is documented to effect results over a sustained period of time. The group dynamics have a healing and rebuilding effect on the participants, restoring a sense of motivation and meaning.

2.3.2 Defining Spirituality

There are many definitions of spirituality, and each definition is unique and of value to different groups of people (Mthembu, Ahmed, Nkuna, & Yaca, 2014; Schulz, 2005), but a single definition that the field of psychiatry and occupational therapy can utilise as a baseline for development of practise models is not available (Simó-Algado et al., 2002; Udell & Chandler, 2000; Unruh et al., 2002). Most articles have defined spirituality with specific reference to their study, none of which can be perceived as incorrect (Schulz, 2005).

An obstacle towards standardising a definition is that concepts within the field of spirituality are as varied as there are cultural streams, and thus its application within a therapeutic setting is limited and avoided by therapists in clinical practise (Unruh et al., 2002). Responses to questions seeking clarity yielded much hesitation and varied responses amongst Australian occupational therapists (Udell & Chandler, 2000). This is particularly relevant in the South African context, in view of the array of cultures within the country's population, each culture holding its own unique set of concepts, values and perceptions with respect to spirituality (R Crouch, 2010; Shaw et al., 2005).

A definition that is more commonly accepted within occupational therapy is the secular definition of spirituality (Unruh et al., 2002). This definition excludes a connection to a higher power as an inherent concept within spirituality, and has come under scrutiny by therapists who may subscribe to religious beliefs including the concept of a God. McColl therefore suggests that spirituality be defined as a sensitivity to the presence of the spirit, where spirit is the shared force that animates all things (Farah & McColl, 2008).

Furthermore, Griffith, Caron, Desrosiers, and Thibeault (2007) highlighted that a connection to a reality beyond the human condition with the ability to positively transform lives was central to the spirituality of their study participants. Schulz (2005) defined spirituality for the purposes of their research as: experiencing a meaningful connection to our core selves, other humans, the world and/or a greater power as expressed through our reflections, narratives and actions.

A recent South African study has developed a definition specific to the South African psychiatric practise context (Janse van Rensburg, Poggenpoel, Myburgh, & Szabo, 2012). The study considers all professional fields within psychiatry, including occupational therapy, nursing and social work. It presents an operational definition of spirituality in the South African psychiatric context as follows:

“In individual persons and societies, the progressive inner quality of transcendental awareness; journey towards understanding of ultimate questions; relationship or connectedness (with themselves, others, the natural world and a theist or atheist presence/source/principle beyond themselves); and a capacity or consciousness concerning an unseen but vital, animating, life defining principle, force or energy within, through which meaning and purpose are derived” (Janse van Rensburg et al., 2012. page 7).

The CMOP-E defines spirituality as a pervasive life force, manifestation of a higher self, source of will and self-determination, and a sense of meaning, purpose and connectedness that people experience in the context of their environment. (Unruh et al., 2002; Wong & Fisher, 2015). This definition is aligned with the belief that spirituality is central to occupational identity, and is thus the core of human occupation. Another definition by Urbanowsky and Vargo aligns spirituality within everyday life and occupation by defining it as a method of obtaining meaning through what humans do (Wilding, 2002).

After consulting the literature regarding operational definitions of spirituality, it became apparent that most studies have defined the concept of spirituality for the specific purpose of their study. None of the reviewed definitions, including CMOP-E were deemed specific and meaningful enough to this population of abused and vulnerable Muslim women. Observing that the researcher and subjects are of Muslim faith, wherein a connection with a higher power (glorified with the name Allah) is practised, the following definition of spirituality for the purpose of this study has been developed by the researcher: ***The nurturance of a connection with Allah, and its manifestation in ones meaning/purpose, coping, and empowerment.*** The definition also considers the subjects diagnosis of trauma and

abuse, as it focusses on key aspects of treatment within this field, namely coping and empowerment.

2.3.3 Defining concepts within spirituality

Some constructs within spirituality that will be mentioned throughout this study include, forgiveness, positive thinking, compassion and gratitude. Each construct will be defined and discussed in this section.

- a. **Forgiveness:** Recent studies have alluded that forgiveness refers to giving up anger and resentment towards a wrong-doer, and that it occurs in the context of a deep, personal and unfair hurt (Carone Jr & Barone, 2001; Sells & Hargrave, 1998). The main function of forgiveness is that it allows one to reduce negative feelings and replace them with positive feelings, irrespective of the offender, and without overlooking or minimising the impact of the offense. Factors that may influence the process of forgiveness include the extent of the anger and one's spiritual beliefs (Sells & Hargrave, 1998).

Forgiveness holds a seat in all practised spirituality's as a central facet of an individual's growth. Of particular interest for this study, is that in Islam forgiveness is included amongst the highest human virtues and is encouraged as a basic principle of conduct, as outlined in many instances in the Holy Quran (Pickthall, 1973; Webb et al., 2012).

As a therapeutic tool, forgiveness is documented as effective in facilitating healthy emotional regulation through alleviating the hormonal response to stress, reducing negative and increasing positive coping responses (Sells & Hargrave, 1998; Webb et al., 2012). Anger towards the self and God can be addressed using forgiveness (Kelly, Hoepfner, Stout, & Pagano, 2012; Moritz, Kelly, Xu, Toews, & Rickhi, 2011). Exercising compassion or empathy towards the offender is a precursor to forgiveness (Carone Jr & Barone, 2001; Webb et al., 2012), resulting in a re-negotiation of the abusive relationship by the less vulnerable victim (Sells & Hargrave, 1998; Webb et al., 2012).

b. Positive Thinking. Human Flourishing is a facet of positive psychology, which focusses on nurturing strengths as a therapeutic tool, rather than diagnosing psychopathology (Coetzee & Viviers, 2007; McEntee, Dy-Liacco, & Haskins, 2013), thus improving the functioning and quality of life, resulting in a flourishing of the client. It is defined as a state in which one feels a positive emotion towards life, and is functioning well psychologically and socially (McEntee et al., 2013). This field of psychology views the capacity to be positive, including feeling love, hope, joy, awe and gratitude, as remnant of spiritual maturity.

A positive view of the future and transformation from negative to positive thinking patterns is an important element of psychological well-being in depressed and para-suicidal individuals following a traumatic event (MacLeod & Conway, 2007; Moritz et al., 2011). Striving for realistic valued goals facilitated positive cognition (MacLeod & Conway, 2007). Linley and Joseph (2004) found that post traumatic growth was consistently associated with positive affect, acceptance, positive re-interpretation and positive religious coping. Trust in a divine will, purification of sins through difficulty and conviction of a divine reward for perseverance through difficulties are amongst positive perceptions of terminal illness encountered as a result of warfare in Iran (Ebadi et al., 2009).

c. Compassion, or empathy, is defined as an ability to view the world through the perspective of another individual (cognitive domain), and to enter into the experiences and feelings of another person (affective domain), and a capability to communicate this understanding (Carone Jr & Barone, 2001; Hojat et al., 2002).

Sympathy is described as the sharing of emotions of another, and exercising sympathy can have negative effects on the therapist/patient relationship, while compassion is a complimentary state of separateness and sharing, which enhances healing (Hojat et al., 2002).

Group and individual therapeutic relationships bear testament to the impact of compassion on psychological well-being. As a key value of the therapist this quality lends itself to a fertile environment which breeds change. Similarly, built into the structure of Alcoholics Anonymous, a group formed in the United States in the 1930's to assist recovering alcoholics, compassion has been alluded to as a stepping stone to spiritual and personal growth (Kelly et al., 2012) Exercising compassion also assisted in creating more positive perspectives in depressed individuals (Moritz et al., 2011).

- d. **Gratitude**, or a grateful disposition, is defined by McCullough, Emmons, and Tsang (2002) as a generalised tendency to recognise and respond with grateful emotion to the roles of other people's benevolence in the positive experiences and outcomes that one obtains A grateful disposition is a precursor to positive emotional experience and subjective wellbeing (Moritz et al., 2011). Research has indicated that grateful people were found to be higher in positive emotions and life satisfaction, and lower in negative emotions such as depression, anxiety and envy. Grateful people were also found to be more spiritually or religiously minded (McCullough et al., 2002).

2.4 ADDRESSING SPIRITUALITY IN OCCUPATIONAL THERAPY GROUPWORK WITH ABUSED AND VULNERABLE WOMEN

This section will focus on the evolution of spirituality within the field of occupational therapy, and spirituality as a coping mechanism. Barriers and opportunities for the practise of spirituality within occupational therapy will also be examined.

2.4.1 Spirituality in Occupational Therapy

The American Occupational Therapy Association's publication titled Occupational Therapy Practise Framework: Domain and Process, defines occupation as all goal directed engagement in self-care, work or leisure activities (AOTA, 2002). The document informs the therapeutic intervention process and outlines seven contexts within which treatment may occur, listing a spiritual context as one of them, and defining it as that which inspires and motivates the individual (Schulz, 2005).

The Canadian Association of Occupational Therapy amended their Occupational Performance Model (1991) to place spirituality at the core of the CMOP-E, replacing occupation (Polatajko et al., 2007). The model depicts spirituality at the intersection of occupation, performance components and the environment, and includes spirituality with the biological, psychological and social elements that make up the individual. A document titled 'Occupational Therapy Guidelines for Client-Centred Practise' was developed based on the model, and stated that in order to fully engage a therapeutic relationship, the clients core being (spirituality) must be fully understood and accepted, and that spirituality is a critical element underpinning occupational therapy intervention towards meaningful living (CAOT, 1991).

Spiritual beliefs may hold key factors which could contribute to treatment compliance and coping (Farah & McColl, 2008; Sherry, 2010). Professionals who deal with individuals struck by illness, injury, impairment and disadvantage, need to consider the potential positive impact of spirituality on the therapeutic process, as well as the potential negative impact of the injury on their patients spirituality (Collins, 1998; Post & Puchalski, 2000). Such individuals have expressed a need for having spirituality addressed by healthcare personnel and settings (Azhar, Varma, & Dharap, 1994; MacLean et al., 2003; Schulz, 2005).

A sense of loss occurs post injury or insult, which is a spiritual struggle (Schulz, 2005), and occupational therapy philosophy dictates that holism and client-centeredness be applied. It should not be assumed that the patient is spiritual, and hence will approve of applying spirituality in the therapeutic setting (Farah & McColl, 2008). An assessment of clients sense of self and spiritual needs should occur (Farah & McColl, 2008; Hess & Ramugondo, 2014), by extending an invitation to patients to share their religious or spiritual beliefs (Alers, 2010; Borneman, Ferrell, & Puchalski, 2010).

The Spiritual Assessment Tool FICA has been evaluated and found to be effective in assessing spirituality in clients (Borneman et al., 2010). It consists of open ended questions that examine four areas of a patient's spiritual history:

- The presence of faith, belief, or meaning (F);
- The importance of spirituality on an individual's life and healthcare decision making (I);
- The individual's spiritual community (C);
- The clients need to and interventions available for addressing spiritual needs (A).

Patients whose spiritual needs are addressed by clinical personnel are more likely to be compliant and responsive to clinical treatment, and spiritual factors often affect illness outcomes in patients (Cornish & Wade, 2010; Post & Puchalski, 2000). A study exploring case studies by occupational therapists found that in five out of seven case studies cited, clients explicitly made reference to religious or spiritual needs, including going to church, special food preparations and someone to pray with (Udell & Chandler, 2000). The role of occupational therapy is seen as the acknowledgement and recognition of spiritual needs, and how they may be affecting function in the individual (Udell & Chandler, 2000). This can be further broken down into three categories:

- Practical spiritual needs: included in the functional assessment, and subsequent therapy plan. Examples of practical spiritual needs include walking to church, or wanting to talk to a pastor (Schulz, 2005).
- Spiritual counselling: is defined as giving direct spiritual guidance pertaining to a belief system or exploring specific spiritual issues in detail, and is not considered within the realm of occupational therapy, or any other mental health care practise (Shaw et al., 2005). Examples include referral to a clergy of the patient's choice.
- Acknowledgement of spirituality of the client involves the client's individual need for space, respect, dignity and someone to talk to. Listening was considered spiritual in a study of students perceptions of spiritual care (Mthembu, Roman, & Wegner, 2015; Teo, 2009). It requires a compassionate and warm human, who allows time to discuss troubles and anxieties, rather than a therapeutic relationship void of soulful connection with a client. The kind and concerned attitude of the therapist is itself acknowledging and respecting the client (Mthembu et al., 2015).

Praying with the clinician has been documented as a need for patients, and it is recommended by ethical standards that the clinician listen respectfully as the patient prays, rather than lead in prayer (Post & Puchalski, 2000). Farah and McColl (2008) argue that praying with the patient is within the scope of practise of, and strengthens the group dynamics and therapeutic relationship. Enabling hope, coping with difficult circumstances and placing the situation in perspective are some listed advantages. The power distribution during the prayer is levelled as both therapist and patient equally focus their energy on a Higher being who is all powerful (Farah & McColl, 2008). Thus the patient is empowered, and the therapeutic relationship is strengthened.

Inherent in occupational therapy is the particular attention to the therapist's attitude when dealing with a patient. This attitude can be likened to the beginning and emergence of a spiritual awakening at a time when the patient's existence is being questioned and a turning point is being sought (Collins, 1998). Meta-skills of compassion, non-judgement, patience and awareness inherent within the profession of occupational therapy dictate that the therapist is already living and manifesting spirituality in all that they do. Addressing spirituality is therefore implicitly inherent in the profession, and the question of its application is perhaps less necessary than acknowledging its presence through a process orientated approach. Similarly, the goal of all occupational therapy interventions, which is to enable occupation using meaningful activity, is also inherently spiritual and implicit in the practise of occupational therapy (Schulz, 2005; Teo, 2009).

Restoring self-esteem through various therapeutic techniques creates positive and hopeful mind-sets. (Cole, 2012; Schulz, 2005). Hope, a form of trust in the future and a recognised therapeutic factor (Yalom, 2005), may be mediated through rituals, meditation, music, prayer, caring relationships and a connection to a higher meaning or purpose (Olpin & Hesson, 2015; Post & Puchalski, 2000). Relaxation techniques including the repetition of a positive and meaningful phrase and combined with passively disregarding intrusive thoughts are reported to heighten spiritual connectedness (Anandarajah & Hight, 2001; Bermudez et al., 2013) and deal effectively with the symptoms of trauma.

Narrative approaches to therapy enhance the meaning or purpose of one's life experiences through the use of stories and metaphors in a manner consistent with occupational therapy philosophy, incorporating values of holism, client centeredness and the significance of person-environment interactions (Kirsh, 1996; Schulz, 2005; Simó-Algado et al., 2002). As a medium in therapy, a life review is written or spoken of, through which personal meaning and purpose in life are derived, one's identity may be enriched, and future possibilities are revealed (Alers, 2010). Spiritual enrichment occurs through retrospective revision of one's life events, and the creation of hopefulness is instilled in projecting one's future (Brody, Cardinal, & Foglio, 2004; Kirsh, 1996).

A huge disparity exists between the importance given to spirituality within the various models of occupation, and its practise in occupational therapy (Mthembu et al., 2015). A number of papers reviewing therapist perceptions regarding addressing spirituality highlighted that therapists concur on the importance of addressing spirituality, but do not feel they 'know enough about it'. They are therefore not comfortable addressing it, which invokes in them feelings of guilt, ambivalence and embarrassment (Cornish & Wade, 2010; Teo, 2009). Although a significant number of patients want to address spiritual matters with clinicians, only sixteen percent of clinicians expressed actually addressing them (Cornish & Wade, 2010; Post & Puchalski, 2000).

This lack of knowledge or understanding begins at tertiary level, where it is not addressed as part of the curriculum in South African and international universities, and extends into practise circles (Farah & McColl, 2008; Mthembu et al., 2015). Some universities have included a course in spirituality, but it was found that interest in the field was low and students were not satisfactorily prepared to address spirituality in practise (Kirsh, Dawson, Antolikova, & Reynolds, 2001). Tertiary institutions still have a responsibility to roll out information and discussion on addressing spirituality, including assessment, ethics and appropriate referral (Post & Puchalski, 2000).

Occupational therapists have also expressed a feeling of transgressing professional boundaries and client's right to privacy when addressing spirituality, and state that

it is primarily the task and role of the clergy (Cornish & Wade, 2010; Wilding, 2002). In response to this, Teo (2009) and Mthembu et al. (2014) state that spirituality is not an activity to be completed, nor is it simply an answer to be found. Rather it is a process of communication and mutual exploration of the caregiver and the care recipient. Unruh clarifies that spirituality is a personal and subjective journey, and that each individual should be free to describe their journey within a framework most relevant to his/her life; that it must mean what it means to the individual and should be respected rather than challenged (Post & Puchalski, 2000; Unruh et al., 2002).

A transdisciplinary approach between occupational therapists and spiritual counsellors can exist, (Farah & McColl, 2008; Human & Muller, 2015), and is described as mutually beneficial to professionals and the client. In Human and Muller (2015) the occupational therapist was able to explain features of the client's physical condition to the clergy, in order to positively influence the therapy delivered. The idea of referring spiritual matters to clergy or spiritual workers is further cautioned against by Brody et al. (2004), who lists characteristics of a spiritual counsellor, and confirms that mental healthcare workers satisfy these requirements:

- One who has understanding of and is conversant with the biomedical aspects of a case (but not necessarily physicians);
- One who has training in psychology (but are not necessarily licensed psychologists);
- One who is skilled in the understanding of human relationships;
- One who is able to integrate the personal meanings of values for both themselves and the patient.

When addressing spirituality, the role of the occupational therapist may be confused by patients as that of a spiritual counsellor, and this should be clarified and cautioned against, as it may cause the patient to disregard therapeutic aims. Co-workers, employers and institution policy-makers may also question the therapist's role in addressing spirituality, fearing that it is a transgression of boundaries. To ensure receptivity of the parties involved, occupational therapist's wishing to apply spirituality to patients should ensure that discussion ensues on the current literature and methods available. Any questions should be answered in an open discussion early on in intervention, to maintain the integrity of the therapy delivered. Consent

for practising spirituality should also be sought from the parties concerned without a sense of pressure or obligation present (Farah & McColl, 2008). Farah and McColl (2008) further suggest that the following questions be answered prior to applying spiritual concepts in therapy:

- Is there a spiritual component to the client's problem?
- Is the therapist equipped to offer spirituality as a modality in treatment?
- Would the client be receptive to addressing spirituality?
- Would the workplace support the use of spirituality in occupational therapy?

A difficulty experienced in addressing spirituality is that one sect of spirituality can be imposed on, or be in conflict with another during the therapeutic process. Conflict may arise between patient and therapist or between group members (Farah & McColl, 2008; Unruh et al., 2002). Another way of stating this is that the therapists spiritual self-awareness should be reflected upon and bracketed (Farah & McColl, 2008; Udell & Chandler, 2000). Clinicians who have no or different belief systems must still consider how to accept the legitimacy of the patients beliefs that may assist them in coping with the illness (Post & Puchalski, 2000) without comprising the integrity of the therapeutic relationship, or their authenticity as therapists (Cornish & Wade, 2010; Farah & McColl, 2008). This point is particularly valid considering that participants of group therapy may be amongst a vulnerable sector of society. However, group therapy is essentially an environment of non-judgement, openness and acceptance, where the group therapist should always be in a position to control and curb group dynamics including overtaking or imposing ideas (Cole, 2012).

2.4.2 Spirituality and Post Traumatic Coping

“Throughout history, some people have adapted to terrible life events with flexibility and creativity, while others have become fixated on the trauma and gone on to lead traumatized and traumatizing existences.” (Kolk, McFarlane., & Weisaeth, 2007 page 3)

The above quote clearly identifies the role of occupational therapy in treating abused and vulnerable women, as observed by other mental healthcare professions. Flexibility, or adapting to change, is the therapeutic aim or purpose of any client-

centered occupational therapy program, whilst creativity is largely used as the medium to facilitate this adaptation, specifically within mental healthcare.

The sequelae of trauma are physiological, psychological, functional and existential. Physiological processes include hyper arousal of the amygdala on the right hemisphere of the brain, creating a surge of emotion and forcing a shut-down of certain functions of the left brain. The release of cortisol during this process is associated with inflammation in the body, resulting in physical symptoms (van der Kolk, 1994).

Rosemary Crouch and Alers (2014) describe 3 phases through which a trauma survivor passes, in order to progress to being a 'thrivor', or an individual who accepts their life experience, and resume their lifestyle previous to the traumatic incident:

- The Impact phase: Prevailing feelings of shock, numbness, disorientation, confusion, disturbed thought patterns, dissociation, emotional lability, or blankness. A sense of hopelessness and helplessness can be combined with a regression to a former stage of development.
- The Recoil phase: Anger, withdrawal and depression may be associated with the dawning of the reality of the situation. Memories and details of the incident may surface, causing distress or guilt.
- Reorganisation or Recovery phase: optimal functioning in daily life routine is achieved, and the traumatic memory is easier to accept. Emotions may arise, but are easily controlled and coping mechanisms are developed.

On a positive note, trauma has been noted to foster a significant change in life priorities, an increased potential to appreciate life and increased importance given to spiritual and religious issues, thereby propelling the individual into a higher level of functioning than previous to the trauma (Linley & Joseph, 2004). Post traumatic growth may result in strengthening of relationships that provide a safe and supportive structure, resulting in individuals feeling stronger, valuing loved ones more, changing life philosophy through greater spirituality (George et al., 2000). A new understanding that life is precious may emerge. Spirituality may catalyse post traumatic growth by enabling an enhanced meaning of life, increased social support,

acceptance of difficulties and having a structured belief system (George et al., 2000; Shaw et al., 2005).

Fallot 1997, in Shaw et al. (2005) states that women who experienced traumatic and abusive histories reported seeing God as a trustworthy refuge. Individuals committed to spiritual goals following major trauma, including murder of a child and a diagnosis of HIV positive, reported having recovered and having found positive meaning to the trauma as an end point to the grieving process (George et al., 2000; Shaw et al., 2005). Spiritual beliefs provide order and understanding to an otherwise chaotic and unpredictable world, and make the incomprehensible understood, the unmanageable manageable, and the unendurable endurable (Carone Jr & Barone, 2001).

Specific spiritual concepts important in transforming the trauma into a growth experience included faith in God, belief in an afterlife, praying and going to church services (Nordien et al., 2003; Shaw et al., 2005). Having a God whose love is universal and unconditional conveys a message that God will love you no matter how cruel and indifferent those around you are, or how insecure and worthless you feel about yourself (Carone Jr & Barone, 2001).

In an Islamic context, Iranians suffering the after effects of war stated that their coping was a function of their trust in the divine will of Allah, prayer and religious duty, illness as a form of purification of sins, and conviction of a divine reward (Ebadi et al., 2009). Quranic verses refer to Allah's attribute of Helper (An-Nasir) and Protecting Friend (Al Wali) (Pickthall, 1973). One such verse located in the chapter dedicated to the treatment of women, states that Allah is an excellent protecting friend, and Allah is an excellent helper (Pickthall, 1973 Chapter 4 Verse 45).

The Quran was revealed in the sixth century, at a time when persecution against females was rife in the Arab world, which conforms with the plight of the abused Muslim woman. Thus the Quran offers much respite. A chapter dedicated to divorce speaks of kindness to the woman, financially and emotionally. Verse 3 speaks of Allah's ability to provide for the parties from sources inconceivable, and re-affirms

that having belief and trust in Allah will ensure sufficient means (Pickthall, 1973 Chapter 65 Verse 3).

A chapter titled "Solace" speaks of burden as something that weighs down ones back. The chapter then affirms from Allah that with hardship there is ease, and repeats this verse giving it conviction (Pickthall, 1973 Chapter 94 Verse 1-8). Ebadi et al. (2009) and Hodge (2005) refer to psychological tranquillity as a reflection of having God in mind, and state that it is recommended that at times of difficulty one should seek help through daily prayer, fasting, exercising patience and remembering God. Also, peace of mind is considered a state that God places in the hearts of believers (Pickthall, 1973 Chapter 48 Verse 4).

However, trauma can offer a fertile environment for developing spiritual struggles, including spiritual disconnection, feelings of abandonment by and anger at God. These negative images have been associated with poor physical and psychological well-being, depression and anxiety (Murray-Swank & Pargament, 2005).

Occupational therapy trauma intervention should be geared towards empowering members of the community to recognise their own potential through meaningful occupations and to work towards occupational justice (Simó-Algado et al., 2002; Wong & Fisher, 2015). When working with women who have been afflicted by abuse and are vulnerable, the aim of intervention is to empower their sense of self and restore internal resources, with the vision to break the cycle of abuse. Using spirituality as a vehicle to accomplish this is potentially transformational.

2.4.3 Programs Currently Applying Spirituality in Healthcare.

This section will highlight documented programs that address spirituality as an intervention. Papers in the field of psychiatry and psychology, community programs, and occupational therapy intervention programs will be highlighted. All the programs discussed are international, and no documented programs could be found in the South African context. Five programmes will be highlighted, namely: Solace for the Soul: A Journey Towards Wholeness; Substance Abuse Recovery and Spirituality; A Spirituality Teaching Program for Depression; An Occupational Therapist's

contribution to Spiritual Care within a Palliative Care setting and Occupational Therapy intervention with children survivors of war.

a. Solace for the Soul: A Journey towards Wholeness (Murray-Swank & Pargament, 2005)

This program is a non-denominational spiritual intervention consonant with five major monotheistic religions. It comprises eight sessions between a trained therapist and victims of sexual abuse who are in long term psychotherapy, for issues including spiritual struggles. The sessions are outlined below:

Table 2.1: Outline of Sessions for Solace of the Soul Program

Session 1:	Orientation and goal setting, Reflection on areas of strength and wholeness
Session 2:	Current images of God using imagery
Session 3:	Therapeutic techniques to identify and Address spiritual struggles
Session 4:	Enhancing a sense of spiritual connection with God and others
Session 5:	Spiritual affirmations and rituals to correct distorted self-perceptions
Session 6 / 7:	Impact of sexual abuse on cognition and spirituality
Session 8:	Future directions

Data collection and analysis revealed that clients were able to transform initial negative images, abandonment and anger issues towards God into a sense of hope and spiritual connection, which was sustained over a 2 month post intervention period (Murray-Swank & Pargament, 2005).

b. Substance Abuse Recovery and Spirituality

Alcoholics Anonymous (AA) is a non-professional organisation that started in USA in 1935 (Shealy, 2009). It is currently a world-wide accepted program that offers a support community for those who want to stop drinking, and other addictive behaviours (Kelly et al., 2012). The program comprises 12 steps for individual treatment, and 12 traditions for group treatment. The structure and content of the program posits to help individuals partly through awakening spirituality and spiritual experiences (George et al., 2000; Piedmont, 2004).

The first three steps of the program promotes acceptance of powerlessness over alcohol, and call for belief and surrender of ones will to Higher Power, through the practise of the following steps (Shealy, 2009):

- We admitted we were powerless over alcohol - that our lives had become unmanageable;
- Came to believe that a Power greater than ourselves could restore us to sanity;
- Made a decision to turn our will and our lives over to the care of God as we understood Him.

The second part of the program supports a thorough examination and acknowledgement of wrongdoings, resentments, and other shortcomings, followed by the making of amends, where appropriate (Shealy, 2009):

- Made a searching and fearless moral inventory of ourselves;
- Admitted to God, to ourselves and to another human being the exact nature of our wrongs;
- Were entirely ready to have God remove all these defects of character;
- Humbly asked Him to remove our shortcomings;
- Made a list of all persons we had harmed, and became willing to make amends to them all;
- Made direct amends to such people wherever possible, except when to do so would injure them or others.

The final steps call for cultivating conscious contact with the God of one's understanding, and offering service to others through the practise of the following steps (Shealy, 2009):

- Continued to take personal inventory and when we were wrong promptly admitted it;
- Sought through prayer and meditation to improve our conscious contact with God as we understood Him, praying only for knowledge of His will for us and the power to carry that out;

- Having had a spiritual awakening as the result of these steps, we tried to carry this message to alcoholics and to practice these principles in all our affairs.

It was found through mediational studies that the value of the AA program lies in its capacity to move an individual from a narcissistic way of life, to a more mature appreciation of love and acknowledgement of the larger dimensions of their lives. Change in the social network of attendees, enhancing spiritual practises, and reducing depressive symptoms are shown to be responsible for change in the behaviour of participants (Kelly et al., 2012; Piedmont, 2004). The compassionate structure of the AA meetings also facilitated self-forgiveness, and nurtured a connection to a higher power and abasement of the ego (Kelly et al., 2012).

Many programs are being facilitated which successfully combine the AA's 12-step program and cognitive behavioural skills components, which have been shown to facilitate mindfulness through acceptance, empathy, compassion and prayer (Kelly et al., 2012).

c. A Spirituality Teaching Program for Depression

Dr Badri Rickhi (Moritz et al., 2011), a psychiatrist at the Canadian Institute of Natural and Integrative Medicine developed an eight week self-study program, that is a non-faith based spiritual intervention. The aim of the program is to nurture spiritual growth by addressing spiritual concepts common to Western and Eastern traditions. The program consists of eight 60 minute sessions, delivered on audio CD each session utilising story-telling and didactic input to present spiritual concepts including the quest for meaning or purpose, connectedness, compassion, acceptance and forgiveness.

Moritz et al. (2011) found that the spiritual component program was successful in facilitating positive cognitive and emotional changes, and thereby impacting positively on recovery from and prevention of depression through the following means:

- Expanded spiritual awareness with the self, others and a universal energy, a deeper sense of individual meaning, and understanding of their own religious faith;
- Cognitive changes from negative to positive thinking patterns, including expressing gratitude and exercising compassion, forgiveness, acceptance and an attitude of non-judgement;
- Openness to multiple perspectives, less emotional reactive-ness and egocentric behaviour;
- A calmer and more composed mood, with an underlying peacefulness.
- Improved relationships.

d. An occupational therapist's contribution to spiritual care within a palliative care setting

Palliative care is defined as active total care of patients whose disease is not responsive to curative treatment, by a multi-professional team. The role of the occupational therapist within palliative Care is inherently and implicitly spiritual in the following ways (Teo, 2009):

- A patient requiring palliative care has experienced loss in areas of diminishing health and social connection, and an inability to fulfil roles. An occupational therapist's ability to restore and maintain their level of function and independence through activity adaptation and environmental modification, is for the patients a matter of respect, as well as a point of hope and positive connection with themselves, ultimately enhancing spirituality (Teo, 2009).
- Many palliative care patients have only their conversation as a remaining resource, and an occupational therapist is able to structure reminiscence and narrative therapy sessions, where their existence is given value, enhancing their meaning and purpose, and facilitating closure. These can also be done in a group session, where the patient benefits from the additional support, acknowledgement, and opportunity for catharsis (Teo, 2009).

- Occupational therapy involves motivated and supportive family members and caregivers, who are committed in their endeavour to be part of the team that cares for the patient and to do for the patient what they can during these days of need. A sense of belonging and connectedness is strengthened for both parties (Teo, 2009).

e. Occupational therapy intervention with children survivors of war (Simó-Algado et al., 2002)

A group of occupational therapists developed a training program for teachers in Kosovo, Albania, aimed at limiting the impact of war on children. Warfare perpetuates children being lost, separated from families, orphaned, tortured, mutilated, sexually abused and kidnapped (Simó-Algado et al., 2002). Amongst a myriad of life long symptomatology, fear, anger, withdrawal and insecurity follow as post traumatic symptoms. Spiritual wellbeing is also documented as being affected (Simó-Algado et al., 2002).

A program of theoretical training was developed, where teachers were educated on mental health, principles of occupational therapy, model of human occupation, logotherapy, secondary trauma and childhood development and intervention techniques. Following the theoretical training, a two week practical was held, where teachers carried out workshops with children. These consisted of two components, the first being a fun session (including a sport, game or song activity) and the second being an emotional expression exercise.

It was found that through these exercises, the children had spontaneously found meaning in their experiences during the war, and in their daily lives (Simó-Algado et al., 2002). Human values of solidarity and love were restored through group cohesion, and replaced anger and hate. Symbols of hope, peace and love were expressed in drawings through doves, flowers and butterflies.

2.5 CONCLUSION

Theories applying spirituality to occupational performance and coping speak to the concept of client centeredness. Group therapy theory and current literature expound on an understanding of, and the effectiveness of this medium with vulnerable populations. With the spate of current literature surrounding spirituality within occupational therapy and mental healthcare, it is increasingly evident that client-centeredness demands that spirituality be considered in assessment and treatment, and group therapy remains an effective means of addressing these populations.

Spirituality is shown to resonate highly as a means of coping. Post traumatic coping is inextricably linked with spirituality, and must therefore be applied to occupational therapy groups with abused and vulnerable Muslim women. The following chapter will explain the methodology of this phenomenological study to understand the experiences of addressing spirituality in occupational therapy groups with abused and vulnerable Muslim women.

CHAPTER 3. METHODOLOGY

3.1 INTRODUCTION

This phenomenological study seeks to explore the experience of addressing spirituality with abused and vulnerable Muslim women within an occupational therapy group program. A group therapy program was designed and administered at a Women's Centre having a spiritual ethos in Durban, South Africa. This study explored the experience of addressing spirituality in occupational therapy groups.

This chapter outlines the study setting and highlights salient features of the group therapy program that was delivered. The research design, sampling and data collection techniques, and procedure are then reviewed. The method of data analysis and ethical considerations conclude the chapter.

3.2 STUDY SETTING

The study focussed on a group of Muslim woman who could meet on a regular basis for a group therapy session with an occupational therapist. A community centre in a Durban suburb that catered for the needs of Muslim women was identified, but reported having a poor response to out-patient groups, and did not have any facility for in-patient therapy, which would be most conducive to a weekly group therapy program. The community centre referred the researcher to a Women's Centre that had an Islamic ethos and offered respite to abused and vulnerable women.

The study was carried out at this Women's Centre, which is registered with the Department of Social Development as a Shelter for Abused and Vulnerable Women since 2011 with a Non-Profit Organisation (NPO) status. It is managed by a Board of Trustees, who are responsible for transparency, quality of care and service, programmes and administration. The Women's Centre is able to house 10 in-patients, and assist with medical and psycho-social care. Spiritual upliftment is a key objective within their constitution (Centre, 2011) and a document outlining the House Rules includes the following that pertain to spirituality:

- All prayer times to be adhered to, e.g. Salah,
- Fasting months/days should be respected by all residents,

- All residents should attend church/madrassa/temple with a view to encouraging spiritual upliftment.

A preliminary consultation with the social worker who represented the Board of Trustees confirmed that no group therapy program was being provided. Residents underwent a week-long admission process including an assessment and individualised follow up sessions with the social worker in attendance, with appropriate referral to other health personnel where necessary. The team of professionals who worked with the women consisted of social workers, trained community workers and activity specialists. Clergy and legal personnel were consulted as required. Discharge was individually planned at the social worker's discretion, with residents being offered out-patient based consultations.

With the Boards permission and a signed confidentiality agreement, the Women's Centre agreed to allow the researcher to commence a weekly occupational therapy group program on a voluntary basis, which was aimed at facilitating empowerment and coping skills with the abused and vulnerable Muslim women. A group therapy treatment plan inclusive of spirituality was developed to improve the occupational performance of the residents. Facilities available included a 50sqm private room where the sessions could be held, kitchen and garden areas, basic furniture, and craft materials. The researcher provided notebooks and pens, and a ream of paper, while printing and copying facilities were provided. There were also individual consultation rooms that could be used for counselling and interviews.

The social worker in attendance often provided insights into the group members, and feedback on the group therapy process was noted in group therapy files. Access to participant's background information was granted to the researcher, excepting notes on individual sessions with other personnel.

3.3 STUDY SAMPLE

The study population were abused and vulnerable Muslim women living at or attending the activities at the Women's Centre. Purposive sampling was used to select those in- and outpatients who attended a minimum of 4 sessions of the group therapy program. Table 3.1 lists inclusion and exclusion criteria for the study.

Table 3.1: Inclusion and Exclusion Criteria

Inclusion Criteria	Exclusion Criteria
Attendance at minimum 4 group therapy sessions	Age <18 years
Of Muslim faith	Psychosis or personality disorder
	Lack of communication and social skills

Over a period of 6 months, 21 patients had attended the group therapy program. Table 3.2 shows how the number of participants (n=7) was obtained.

Table 3.2: Attainment of actual sample size (n)

	Number reduced by:	Participants remaining:
Individuals in group sessions		21
Group attrition	4	17
Discharged before being interviewed	4	13
Out patients defaulting appointments	2	11
Unsuitable to be interviewed *	2	9
History of psychosis**	1	8
Not of Muslim Faith	1	7

*Participants were excluded based on their lack of communication and social skills as observed in the group therapy sessions by a lack of interaction and depth of responses.

**Participant did not have active signs of psychosis, and was therefore allowed to attend groups, but was excluded from the study based on a history of psychosis, and the potential for a recurrence.

3.4 THE GROUP THERAPY PROGRAM

Although the effectiveness of the group therapy sessions is not measured as part of this study, it is important to consider the group therapy process that the participants engaged in. This will enhance the value of the findings and discussion.

It was enforced by the centre's care-givers that residents attended all group sessions as part of the treatment program offered, unless a valid reason was stated for non-attendance. The group constituted all in-patients, as well as out-patients who were invited by the social worker to attend. The sessions were open in that new

participants were allowed to join the sessions at any point, and homogenous based on gender and diagnosis. The 7 sessions described below were conducted weekly, and lasted approximately 2 hours each. The program was then repeated thrice over a period of 6 months.

Occupational therapy group sessions were designed by the researcher, using psychodynamic and psychoeducation models (Cole, 2012) to assist abused and vulnerable Muslim women to cope, regain confidence and feel empowered. Yalom's therapeutic factors (Yalom, 2005) guided the group dynamic, and spiritual issues around the subject matter were incorporated (Hodge, 2005).

The group program was aimed at addressing trauma and facilitating better coping skills, and is further explained below:

a. Community Artwork Project

The use of art is a well-accepted medium in occupational therapy, and easily accommodates cultural values, symbolic meaning and self-expression (Cole, 2012; R Crouch, 2010). Art therapy has a positive effect on self-esteem, emotions, and discharges tension and anxiety (Olpin & Hesson, 2015; Pretorius & Pfeifer, 2010). The group engaged in a task centered group artwork project which was made to be displayed at the head office of a local Islamic community hospital.

The activity and materials were introduced, rules were established and anxieties were allayed. Each group member then contributed to the design and execution, which included the inscription 'In the name of Allah, Most Merciful, and Most Compassionate' in Arabic calligraphy (Figure 3.1). On reflection, the participants felt a sense of pride, which was a precursor to self-worth and self-esteem.



Figure 3.1 Artwork By Group Members at the Women's Centre

a. Craft Day with a Youth Club

A special event was proposed to the group participants, which they expressed much positive emotion around. It was arranged with the centre, that children from a community youth club attend the Women's Centre to be taught various crafts by the residents. This activity was aimed at improving self-esteem and social skills.

Participant engaged in planning the events and logistics for the day, and took charge of interacting with the children. A participant was appointed to give the children a background to the centre, and a vote of thanks from the children was heart-warming.

A cake decorating demonstration was held, where the residents assisted the children with making roses from sugar paste to decorate a cupcake. In addition, the residents taught the children bead making, and assisted the children with making salad and a simple desert that were served at lunch. An evaluation of the group yielded much positive emotion and meaning. Some participants also expressed wanting to pursue a career in cake decorating.

c. Stress Management

Stress management has been noted as a vital area of intervention to the trauma survivor, and should be applied during the recoil phase (Alers, 2010; Gorde, Helfrich, & Finlayson, 2004). Stress management was introduced as a factor affected by lifestyle including diet, exercise, constructive use of leisure time, communication and time management (Olpin & Hesson, 2015). Appropriate exercises on each of these areas followed. Participants were asked to reflect on their use of time, and balance in their lifestyle. Spirituality was introduced as all-encompassing factor in the daily routine of a Muslim woman (Hodge, 2005; Olpin & Hesson, 2015).

In addition to the theory around stress and time management, the remembrance of Allah through Zikr (repetitively praising Allah using His glorified names and attributes), expressing gratitude and striving for balance were some spiritual concepts mentioned as inherent in any aspect of daily living, giving meaning and purpose to existence. Personal management and work were also viewed from a spiritual lens, which was received by the women as a fresh perspective. The group then engaged in reflecting on their own lifestyle through creative writing (Cole, 2012).

d. Relaxation Therapy

Relaxation and breathing techniques are seen as key in regulating the body and mind to a sense of serenity and security following trauma (Alers, 2010; Anandarajah & Hight, 2001; Echeburúa et al., 2013). Mindfulness, or paying attention to one's present experiences during the practice of meditation (Bermudez et al., 2013) incorporates breathing techniques in order to manage emotional distress (Olpin & Hesson, 2015). Relaxation techniques lasting twenty minutes were conducted regularly at the Women's centre, usually concluding the day's session. Attributes of Allah were invoked in conjunction with abdominal breathing and visualisation (Hodge, 2005), for example Ya Wadud (Most Loving) and Ya Salaam (Most peaceful). This facilitated a heightened and nurtured sense of connectedness to Allah. The following is a section of text used for relaxation:

“Listen for the sound of your in breath..... Feel your abdomen and rib cage expand and relax..... Listen to the sound of your out breath..... In your minds eye, hold a vision of something symbolic for you of love and peace and tranquillity..... Just sense that energy... of love... and peace... and tranquillity..... feel that energy grow boundlessly all around, Ya Wadud Ya Salaam Most Loving, Most peaceful.....”

e. Communication and Assertiveness

Role play was adopted as the medium to address communication and assertiveness skills (Cole, 2012). The content was presented initially, including body language features and assertive communication. Listening skills were also discussed, including reflection of thoughts and feelings, gestures of acknowledgement and empathy. The group then chose meaningful scenarios to role-play, participants volunteered to role-play, and feedback and process followed (Cole, 2012).

Recognising communication as a tool to enhance meaningful occupation was encouraged as a discussion. Spiritual factors that emerged included communication being a gift from Allah; communication as a means of being respectful and compassionate to others; communication improving your meaning of and experience of life (Hodge, 2005).

f. Psychodrama

Psycho-drama, developed by Moreno, is a technique that often helps facilitate expression of emotions and finding meaning where negative emotion is being harboured following a traumatic and abusive incident (Alers, 2010; Echeburúa et al., 2013). It was employed as a technique to deal with the protagonist's (group participant) resentment against her parents. A specific scenario depicting a rape incident was re-created, and the protagonist was afforded the opportunity to give expression of her deepest feelings for the first time (Yalom, 2005) in a safe and controlled environment.

Group members assumed supporting roles, and showed empathy, while the protagonist was cathartic. The protagonist was able to overcome many

barriers, and sustain that change in perception (Echeburúa et al., 2013; Pretorius & Pfeifer, 2010), while many other group members assumed a shift in perception by observing this process (Yalom, 2005). Spiritually, the forgiving nature of Allah (Ya Gafur) was explored, giving meaning to the process of forgiveness (Hodge, 2005) and closure was gained with a prayer conducted by the protagonist for the deceased (Cornish & Wade, 2010; Farah & McColl, 2008).

3.5 SPIRITUAL CONCEPTS ARISING IN GROUP THERAPY

Many concepts within Islamic spirituality were mentioned during the group therapy sessions, initiated either by the therapist or the participants. The group members were always allowed to give insight into how they perceived the mentioned concepts, albeit a different perspective. The concepts were always integrated into the topic at hand.

a. A Connection with Allah

A connection with Allah was seen as giving meaning or purpose to one's existence. This concept also highlighted the Omni-presence of a higher power, and the constant nature of the connection. Allah has 99 attributes that are mentioned in the Quran. Amongst them are Ya Wadud (The Most Loving), Ya Salaam (The Most Peaceful), Ya Nasir (The Helper), Ya Hafiz (The Protector), Ya Qawi (The most Strong) and Ya Latif (The Most Gentle).

b. Maintaining a positive mind-set:

Positive thinking strengthens a connection with Allah, and the outlook on any situation. And to recognise negativity in ones thought pattern is a precursor to create this perception shift. Awareness of thought patterns was encouraged through introspection/reflection and journaling.

c. Attitude of Gratitude

Contemplating and recognising the depth of blessings bestowed upon one's person is both a form of prayer as well as source of self-worth and contentment, within which lies a powerful coping mechanism. Gratitude may manifest on various levels, the first being the ability to generate thoughts of

thankfulness, which again reinforces a positive mind-set. A more intense level is to express the gratitude verbally, in writing or other creative means, and an even more intense and meaningful manner of expressing gratitude is through actions and behaviour that shows gratitude.

d. Active acts of remembrance and contemplation (Zikr):

This is regarded as an act of high stature in the realm of Islam, and should be carried out voluntarily and solely for the pleasure of Allah. It can be likened with active relaxation techniques and meditation, which literature points to as being a positive experience in mental wellbeing. Attributes of Allah are chanted, silently or aloud, in a structured fashion, to assist in manifesting those qualities within, and to radiate through actions of daily living.

3.6 RESEARCH DESIGN

A phenomenological study describes the common meaning of a *lived experience* for several individuals, and seeks to reduce what and how individuals experienced the phenomenon into a universal essence (Creswell, 2012). Researchers identify a lived experience to be examined, collect data from persons who have experienced the phenomenon, particularly asking *what* the participants experienced (textural descriptions) and *how* it was experienced (structural descriptions). The researcher then composes a description of the essence of the experience (Creswell, 2012).

Bermudez et al. (2013) conducted a similar study on a group of women who experienced intimate partner violence. They explored the women's experiences of attending an 8 week Mindfulness Based Stress Reduction group. The study was longitudinal, and they conducted semi-structured interviews at various points after the group. Data collection concluded with a focus group at 9 months after the group. Transcripts were transcribed and a system of thematic analysis ensued. However, this study did not outline the development of the interview schedule. Galvaan et al. (2015) were consulted on the development of the interview schedule for their hybrid study, including inserting probes. Graneheim and Lundman (2004) were consulted on thematic analysis using content areas which separated inductive and deductively reasoned data.

With *spirituality in group therapy* being the phenomenon explored, phenomenology was selected as an approach to this qualitative study located in the interpretive paradigm. Phenomenology requires individual input from several participants (Bermudez et al., 2013; Creswell, 2012), and semi structured interviews were selected to meet this requirement. The research question lent itself to examining *what* the participants experienced (textural description), and *how* they experienced the phenomenon (structural description).

Features of a phenomenological study include analysing data from significant statements to broader units (codes and categories), and then detailed elements that summarise textural and structural descriptions. Finally, a phenomenological study concludes with a passage describing the essence of the experience (Creswell, 2012).

This study explored the above features by employing thematic analysis. A hybrid method of both inductive (data emerging from the text) and deductive reasoning, (where specific information that corresponded with the literature) was utilised (Galvaan et al., 2015). Establishing an understanding of a definition of spirituality is one example of deductive reasoning being applied. Data was represented under the sub headings of themes in chapter 4, including textural and structural descriptions and a statement of the essence of the findings.

3.7 DATA COLLECTION TOOLS

Semi - structured in-depth individual interviews were conducted by the researcher. An interview schedule was prepared that included biographical data (excluding interviewee name), open ended questions related to the experience of addressing spirituality in group therapy, defining spirituality, and spirituality as a coping mechanism. This section will outline the rationale for selecting semi structured interviews, as well as describe elements included in the interview schedule.

3.7.1 Semi-Structured interviews

Semi structured interviews allow for open ended disclosure of what the participants experienced and how they experienced the phenomenon in question (Creswell, 2012), predisposing it to a phenomenological study. Semi structured interviews also

encourage detailed and rich data (Remler & Ryzin, 2011), and spirituality is underpinned by personal and cultural contexts in any community and individual interviews provided the best platform to study cultural and context-bound subjects (Ebadi, Ahmadi, Ghanei, & Kazemnejad, 2009).

Focus-groups were not used as primary data collection tools in this study, as this method may result in the data being skewed towards the dominant voices within the group. This was particularly important given the vulnerable nature of the participants, and the potential to minimise their presence within a focus group.

As the study is of a hybrid nature, and not purely inductive, a degree of structure was required to facilitate collection of specific data that related to the literature and research question, deductively, as applied by Fereday and Muir-Cochrane (2008). Semi-structured interviews followed an interview guide, which is a set of short questions that help structure the discussion. The questions were structured to be open-ended beginning mostly with “what” or “how”, and included prompting questions, to deduce specific information. The information sourced deductively included a definition of spirituality as the participant understood it, and an understanding of how the group therapy sessions impacted on the participant’s connection to a higher power, sense of meaning and purpose. Prompting questions were required when the content of the interview did not provide enough description (Galvaan et al., 2015).

3.7.2 The Interview schedule

Semi-structured individual in-depth interviews with 12 items of discussion were conducted by the researcher, as represented in Table 3.3. An interview schedule was prepared that included the following components (Appendix 6), and prompting questions were asked based on the content of the interview and guided by the literature and research question (Galvaan et al., 2015).

Table 3.3 Structure of Interview Schedule

A. Biographical Data	B. Experience of group therapy	C. Addressing spirituality
<input type="checkbox"/> Interview number <input type="checkbox"/> Age <input type="checkbox"/> Gender <input type="checkbox"/> Religious affiliation <input type="checkbox"/> Reason for admission at the centre <input type="checkbox"/> Previous intervention	<input type="checkbox"/> How do you feel about the group therapy program offered at the centre	<input type="checkbox"/> How do you understand spirituality? <input type="checkbox"/> Do you think group therapy was a good place to talk about spirituality? <input type="checkbox"/> Do you think it is better to talk to a moulana or aalima? <input type="checkbox"/> Tell me about a session that impacted on you the most? <input type="checkbox"/> Do you think the groups helped to strengthen your connection to Allah?

a. Biographical data

Item 1 on the interview schedule was the interview number, which was needed for reference to the transcripts. Biographical data was recorded to ensure that participants met the inclusion and exclusion criteria in terms of age, gender, and Muslim faith (Questions 2-4). An open ended Question 5 asked their reason for being admitted at the Women’s Centre and ascertained that some trauma had taken place resulting in the admission, as well as creating a platform for open discussion, establishing rapport and alleviating anxiety. Participants were also asked in Question 6 if they had experienced group therapy previously, accounting for previous exposure to group therapy.

b. Experience of the group therapy program

Question 7 asked how the participant felt about the group therapy program that was presented at the centre. According to phenomenology, this question answered *what* participants experienced, and gave structural descriptions (Creswell, 2012). Participant’s experiences of the group therapy dynamics were also captured through this question.

c. Addressing Spirituality

Given that no universally acceptable definition of spirituality exists, Question 8 asked for a definition applicable to abused and vulnerable Muslim woman. This data was obtained deductively, by specifically asking the participant for a definition. Prompting questions included establishing if a difference between religion and spirituality existed in the mind of the participant, if a definition of spirituality included its use as a coping mechanism, and if the participant's family background and experiences with spirituality has impacted on their current perception of spirituality. This question spoke to objective 1 of this study, which sought to explore a definition of spirituality for abused and vulnerable Muslim women.

Questions 9 and 10 were designed to obtain information around objective 2: To establish the scope of occupational therapy group practise in the Muslim faith. The role and client-centred nature of spirituality within the occupational therapy group was addressed in Question 9: Do you think that group therapy was a good place to talk about spirituality? The participants feelings associated with addressing spirituality within the group therapy session were also examined in Question 9. In order to balance positive and negative viewpoints, participants were prompted to identify and express feelings of intimidation, vulnerability or discomfort.

Addressing spirituality is traditionally the responsibility of clergy and theologians. This was addressed deductively by enquiring if the participants preferred talking to an Aalim or Moulana (Islamic clergy) on spiritual matters. This concept was initially a prompted question under Question 9, but it was converted it into a separate question on the interview schedule after the first interview, and was asked to all participants as Question 10. The information obtained through this question was relevant to the literature, research question and objectives.

Finally, the data was enriched by discussing specific constructs that were defined and addressed in the group sessions. Question 11 was thus phrased: 'Tell me about a session that impacted on you the most? This question related

to objective 4, stated as: To explore abused and vulnerable Muslim women's experiences of including spiritual constructs in an occupational therapy group program. Further to a discussion on a specific session that came to the mind of the participant, the participants were probed on other constructs that were addressed, including positive thinking, gratitude and stress management.

Questioning the practical application of these constructs into the daily lives of these women provided insights into how spirituality had aided them in coping, seeking to answer objective 3: To explore abused and vulnerable Muslim women's experiences of spirituality as a coping strategy. This questioned answered the *how* aspect of the phenomenon in question.

A further prompting question regarding the participant's establishment of a connection with Allah and a sense of meaning or purpose in their lives was originally included in Question 11. However, this was converted into Question 12 during interview 1 of the data collection process, as a connection with a higher power was central to the concept of spirituality for the purpose of this study. It was essential to establish if this construct could be impacted on during a series of occupational therapy groups, and whether the groups enhanced a sense of meaning and purpose for the participants.

3.8 DATA COLLECTION

As the weekly group program was conducted, participants who attended a minimum of 4 sessions were identified, an appointment with the researcher was scheduled, when the following was outlined:

- the aim and method of the research, including audio recording and storage;
- confidentiality, anonymity and right to withdraw from the study at any stage;
- ethical clearance and permission from the Board of Trustees;
- participants needed to sign an informed consent document.

The interview was conducted in a private room at the Women's Centre, and started with an explanation of the title and aims of the study. The procedure was outlined and the consent form was explained, and the participant was required to sign a copy. A voice recorder was strategically placed out of direct view of the participant to

prevent anxiety. The interview lasted approximately an hour and was conducted by the researcher, who in this case was also the therapist who conducted the group sessions. The interview was concluded by thanking the interviewee. The interviews were conducted after the participant had attended 4 group therapy sessions. The program was still being conducted, and the participant could therefore attend further sessions until her discharge.

The interview recording was saved on the voice recorder under a numbered file, which was recorded on the interview schedule. The file was transferred to a laptop via USB cable, where it was kept under the same file name and stored under password protection, for later analysis.

3.9 DATA ANALYSIS

Thematic analysis is a method for identifying, analysing and reporting patterns (themes) within data that are important to the description of the phenomenon (Fereday & Muir-Cochrane, 2008). It minimally organizes and describes a data set in (rich) detail, and interprets various aspects of the research topic (Braun & Clarke, 2006). Thematic analysis was deemed appropriate for this phenomenological study, as the emergent themes obtained from the semi-structured individual interviews could reveal in-depth structural and textural descriptions, and a thorough understanding of the essence of spirituality in coping,

A dedicated transcriber was employed, who signed a confidentiality agreement. The interviews were transcribed verbatim and saved under password control on the researcher's laptop. The transcripts were then proofread against the recordings and re-read for familiarity (Creswell, 2012; Fereday & Muir-Cochrane, 2008; Saldana, 2009).

3.9.1 Allocation of Pseudonyms

Prior to the analysis being conducted, the participants were assigned pseudonyms that corresponded with Muslim women throughout the history of Islam. This was done in place of using their names as unique identifiers, with the women being allocated the following names:

1. Hawa, the wife of Prophet Adam.
2. Maryam, the mother of Prophet Esa (Jesus).
3. Amina, the mother of Prophet Muhammad.
4. Khadija, the wife of Prophet Muhammad
5. Fatimah, daughter of Prophet Muhammad
6. Ayesha, the wife of the Prophet Muhammad after Khadija had passed away.
7. Rabia, a Sufi mystic.

Once the names had been allocated, thematic analysis could begin, which entailed identifying content areas which related to corresponding questions, and these were thematically analysed, as will be described in the following sections.

3.9.2 Content areas

Graneheim and Lundman (2004) describe a content area within thematic analysis as a part of the text based on theoretical assumptions from the literature, or parts of the text that address a specific topic in an interview. Being a hybrid study, the text is divided into content areas, and analysed one content area at a time. The researcher identified six content areas that corresponded with interview questions asked:

- Experience of group therapy,
- Definition of spirituality,
- Experience of spirituality within the group therapy session,
- The role of clergy in spirituality,
- Spirituality and coping,
- Strengthening a spiritual connection.

The six content areas were indicated by different highlighted colours, on each interview transcription. The researcher chose a content area to analyse, and re-read that section of all seven interviews, jotting down thoughts or memos as they were read.

3.9.3 Coding

Statements about how participants experienced the phenomenon were then highlighted as meaning units (Creswell, 2012; Graneheim & Lundman, 2004; Saldana, 2009). The meaning units were captured onto an Excel spreadsheet, with an adjoining column headed 'condensed meaning unit'. A condensed meaning unit is a shortened version of the meaning unit, while still preserving the core (Graneheim & Lundman, 2004).

A third column labelled 'Code' was where the researcher assigned a word or short phrase that symbolically provides a summative, essence capturing attribute to the condensed meaning unit (Saldana, 2009). Codes were then described and defined (Fereday & Muir-Cochrane, 2008), and significant statements were abstracted or grouped together under the code in a new table (Graneheim & Lundman, 2004), as shown in Table 3.4.

Table 3.4 Example of Abstraction into Codes

CODE 1:		
LABEL:	CONNECTION	
DEFINITION:	A SPIRITUAL CONNECTION WITH ALLAH	
DESCRIPTION:	MEANING UNITS WHICH MAKE REFERENCE TO A CONNECTION WITH GOD, THE UNIVERSE AND OTHERS AS A DEFINITION OF SPIRITUALITY	
PARTICIPANT:	MEANING UNIT	CONDENSED MEANING UNIT
2. MARYAM	CONNECTING WITH GOD, CONNECTING WITH YOURSELF AND THE UNIVERSE	UNIVERSAL SPIRITUAL CONNECTION
	THERE CAME A LOT OF SIGNS OVER A PERIOD OF TIME	RECEIVED SPIRITUAL SIGNS
	IT'S ALMOST LIKE ALLAH'S CALLING ME	FELT A CALLING TO ALLAH
	I FOLLOWED MY HEART, THE SIGNS WERE THERE	FOLLOWED HEARTFELT SIGNS
3. AMINA	HOW SOMEBODY IS CLOSE TO ALLAH	CLOSENESS TO ALLAH
	ESPECIALLY BEING CLOSE TO GOD	ESPECIALLY CLOSENESS TO ALLAH
4. KHADIJA	YOU LOOSE YOUR CONNECTION TO HIM	SPIRITUAL CONNECTION CAN WEAKEN
	THE STRONGER U BUILD THAT CONNECTION, THE STRONGER YOU WILL BECOME	SPIRITUAL CONNECTION CAN BE STRENGTHENED WITH EFFORT
	WHEN I LOST THAT CONNECTION I WAS WEAK... I COULDN'T CONCENTRATE... THINGS GOT WORSE	WEAK CONNECTION MAKES U EMOTIONALLY WEAK

In order to revisit the codes, the transcripts were then re-read and re-coded to account for significant statements relating to a particular code that, may have appeared outside of a particular content area. For example, a definition of spirituality may have appeared in the content area titled 'Experience of group therapy', which was then added onto the corresponding table.

3.9.4 Themes

Statements that *looked* and *felt* alike, and share some characteristic were organised to form an emergent theme (Saldana, 2009). Creating themes is a way to link the underlying meanings across the categories and to describe an aspect of the structure of experience (Graneheim & Lundman, 2004). The data was analysed using these guidelines, and the process was repeated to refine and review emergent themes. At the final stage, the process of analysis was scrutinised to ensure that themes were representative of the data and codes in the previous stages (Fereday & Muir-Cochrane, 2008).

3.10 TRUSTWORTHINESS AND RIGOUR

Trustworthiness of a qualitative study is defined by credibility, dependability and transferability (Graneheim & Lundman, 2004), and these concepts will be further outlined as they applied to this study. Establishing rigor involves efforts to confidently represent the thoughts, meanings and experiences of the participants (Lietz, Langer, & Furman, 2006), and the authors present concepts of rigor as specifically applied to a study on spirituality. The factors affecting trustworthiness and rigour discussed in this study are credibility, dependability, transferability, reactivity bias, member checking and prolonged engagement.

3.10.1 Credibility

Establishing credibility relates to how well the data and process of analysis addresses the focus of study. Credibility was achieved in this study through appropriate context and participant selection, appropriate data gathering approaches, reliable amount of data and suitable meaning units, and establishment of representative themes.

a. Selection of context, participants and approach to gathering data

The study site was an in-patient Women's Centre, which facilitated participant's regular attendance at group sessions, and ensured that participants were available for the interview, as opposed to poor compliance in an out-patient facility. Furthermore, out-patients may have been consumed and distracted by their responsibilities outside of group time, which may have affected interview responses. The centre management supported the group attendance and interviews wherever possible.

Having a common religion enhanced the group dynamic and facilitated openness. The positive effect of sharing a common concept of spirituality within the therapist-patient dynamic has also been alluded to in some studies (Azhar et al., 1994; Moritz et al., 2011; Worthington & Sandage, 2001) and will enhance the depth, reliability and validity of the data obtained.

Limiting the study to the Islamic faith also simplified data analysis and discussion. Participants were of varying cultures within the Islamic faith, including Nigerian, Kenyan, Indian and a recent revert to Islam. The data therefore offered rich variations to the phenomenon under study.

Semi-structured interviews are a common and reliable method of data collection in a qualitative study. The researcher's background in psychiatric occupational therapy ensured that the interview was approached with empathy, and where skills of reflection, openness and probing were employed.

b. Amount of data and suitable meaning units

Data was obtained from all participants meeting the inclusion criteria (n=7). Although saturation of data could not be reached, the opinions presented are rich without being vastly differing, and concur with the literature.

Meaning units highlighted during thematic analysis varied from full sentences to six lines of discussion, which enhanced credibility, as it limited fragmented data when using single words for analysis. Broad data units can complicate analysis due to varying themes being present in a single meaning unit.

c. Establishment of themes that represent data

Peer debriefing was employed, which entailed discussing the coding and theme development. Academics in the field of Islamic spirituality were also consulted on theme development. Credibility will be enhanced by presenting appropriate quotations from the text for the theme under discussion.

3.10.2 Dependability

Dependability refers to the extent to which the data changed over time and if alterations were made in the researchers decisions during the data analysis. A more extensive and time consuming process predisposes a study to issues of dependability. This study consisted of a collection of seven interviews over six months, which was controlled for dependability.

During the data gathering process, one change was implemented in the interview schedule, after the first interview, which acted as a pilot study. The question asking how the participant experienced the group therapy program presented included a probe on whether group attendance helped to strengthen their connection or sense of meaning or purpose. The richness of the data obtained from the first participant lead to the researcher including it as a separate question in the following six interviews. The same applied to a probe on whether the participant thought speaking to a Muslim cleric was the same as addressing spirituality in group therapy. No further changes were instituted to the data collection process.

3.10.3 Transferability

Transferability refers to the extent to which the findings can be transferred to other settings or groups. The researcher has provided extensive descriptions of the context, group therapy process and methodology, and included quotations representing the findings, which enhance transferability of the study.

Transferability of the study would also be dependant on the therapist's facilitation of the group therapy program prior to the interviews. Details of the concepts of spirituality included in the program have been described in this chapter in order to guide the therapist in conducting the process. The program can vary in elements depending on the needs of the group members.

Transferring this study to groups of women from spiritual sects other than Islam is also a possibility. However, the group therapy program would need to be designed to suit that specific context.

3.10.4 Reflexivity

Reflection should occur throughout the stages of the research. In keeping with co-constructivism, the researcher's values, prejudices, beliefs and attitudes will likely influence the data analysis process. In order to maximise the participant's voice in the stated research, it is important to state and interrogate the researcher's involvement with the phenomenon being studied. A statement of reflexivity was written stating the researchers experience with Islamic spirituality and abusive relationships, as presented in chapter 1.

The researcher's pre-existing notions of the benefit of addressing spirituality has also been bracketed, as well as the dynamic created by the therapist being the researcher.

3.10.5 Member checking and Prolonged Engagement

Member checking during the interview was done through reflection and clarification during the interview, and this further validated the data. The researcher had reflected the opinions of the participant in order to clarify and accurately reflect the participant's viewpoints. Participants were asked permission to contact them in future to clarify any ambiguous content during the data analysis. Unfortunately it was not possible to discuss results and themes with the participants in a focus group, as most had been discharged at this stage of the research.

During the process of engaging in group therapy at the Women's Centre, the researcher spent extensive time with the participants. This facilitated increased rapport leading participants to be more open in their interactions with the researcher, and to express their responses openly and honestly. Due to this therapeutic relationship over an extended time, the Hawthorne effect may have impacted on results (Leonard & Masatu, 2006). To limit this effect, it was re-iterated that there was no right or wrong response, and that negative feedback would be welcomed.

Member checking the themes that emerged with a focus group as a means of triangulation data was not conducted as participants had been discharged and were unable to attend a focus group thereafter. This hampered the trustworthiness of the report.

3.11 Ethical Considerations

Ethical clearance was obtained from Humanities and Social Sciences Research Ethics Committee at the University of Kwa-Zulu Natal (Appendix 1 a). A grammatical amendment to the title of the study was also ethically cleared, and the amendment letter is included in Appendix 1 b. Permission to undertake the study was obtained from the Women's Centre. The Board of Trustees were informed of the studies aims, objectives and methodology, and written consent was obtained from a representative (Appendices 2 and 3).

Participants were informed about the motives of the study both orally and in writing during individual appointments, and assured of confidentiality and anonymity. Pseudonyms were used to further enhance confidentiality. They were informed that their participation in the study was voluntary and that they could refuse to participate or withdraw from the study at any stage without being penalized. Moreover, the participants were reassured that their responses would be kept confidential and their identities would not be revealed in research reports or in the publication of the findings. An informed consent form was signed (Appendices 4 and 5).

Participants who required individual counselling further to the interview session regarding issues that may have emerged during the interview were individually consulted by the researcher, and referred to the relevant sources.

Results of this study will be presented to the Board of Trustees at the Women's Centre to facilitate more holistic and client-centered program planning, and to advocate the role of occupational therapy groupwork with abused and vulnerable Muslim women.

3.12 CONCLUSION

Phenomenology was applied to this study in order to incorporate spirituality as applied to occupational therapy groups. A series of groups were conducted at a Women's Centre, and the meaning of addressing spirituality in the group sessions was explored. The research design was adapted from various researchers to create a unique study. Semi-structured interviews were conducted and thematic analysis ensued. Ethical considerations are discussed. The findings are presented in the following chapter as quotations expressing the emergent themes. Textural and structural descriptions will precede an attempt to capture the essence of the theme.

CHAPTER 4. FINDINGS

4.1 INTRODUCTION

This chapter will provide a brief profile of each of the seven participants, including biographical data and a brief history. Thematic analysis was conducted as described in Chapter 3, using a combination of methods. A hybrid approach (Fereday & Muir-Cochrane, 2008) accounted for both an inductive and deductive reasoning method. Coding and theme development was done as outlined by Saldana (2009) and Creswell (2012).

The four main themes that emerged are shown in Figure 4.1, and the objectives that they correspond with are graphically represented in Figure 4.2. Sub-themes and categories will be discussed in this chapter under the relevant sub-headings, and themes will be presented including a description of the theme and participants responses as quotations from the transcriptions. In keeping with phenomenology, structural and textural descriptions will conclude each theme, and an attempt to capture the essence of the theme will be offered.

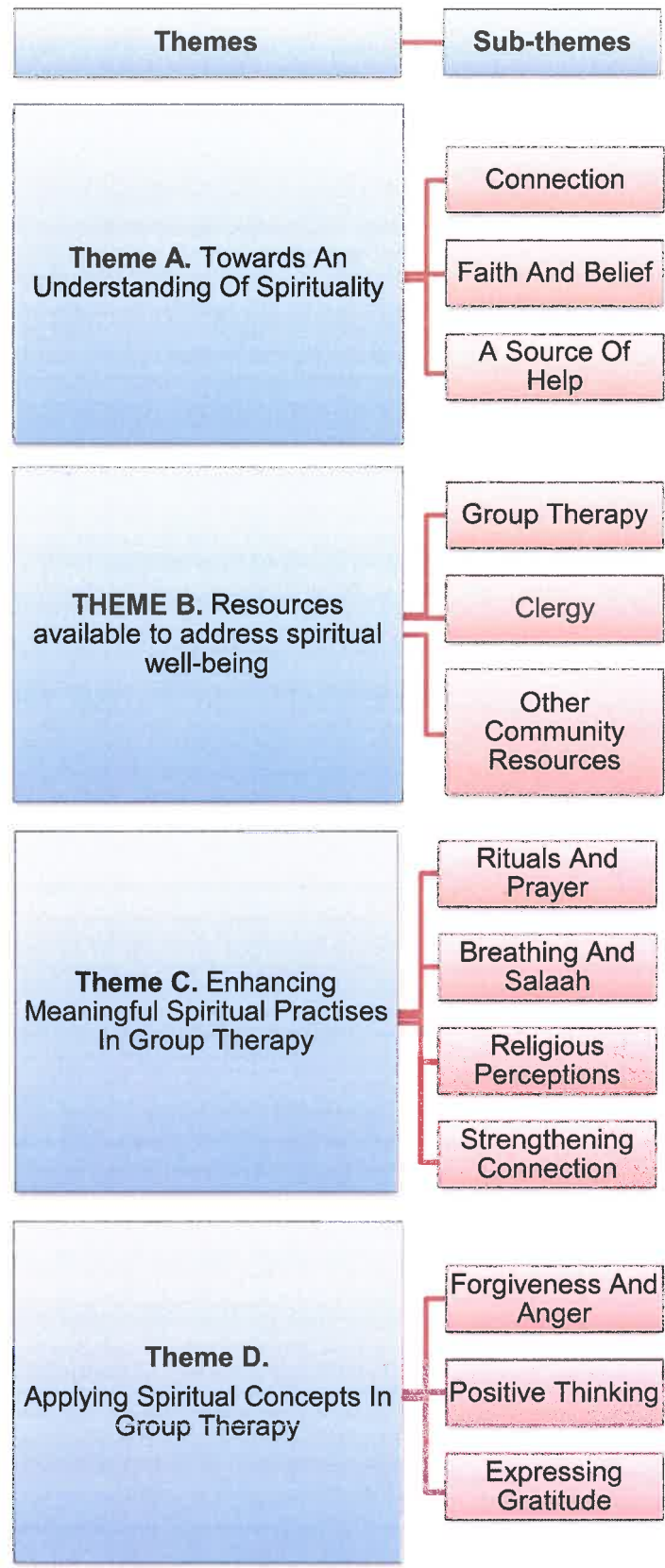


Figure 4.1 Themes, Sub-Themes and Categories

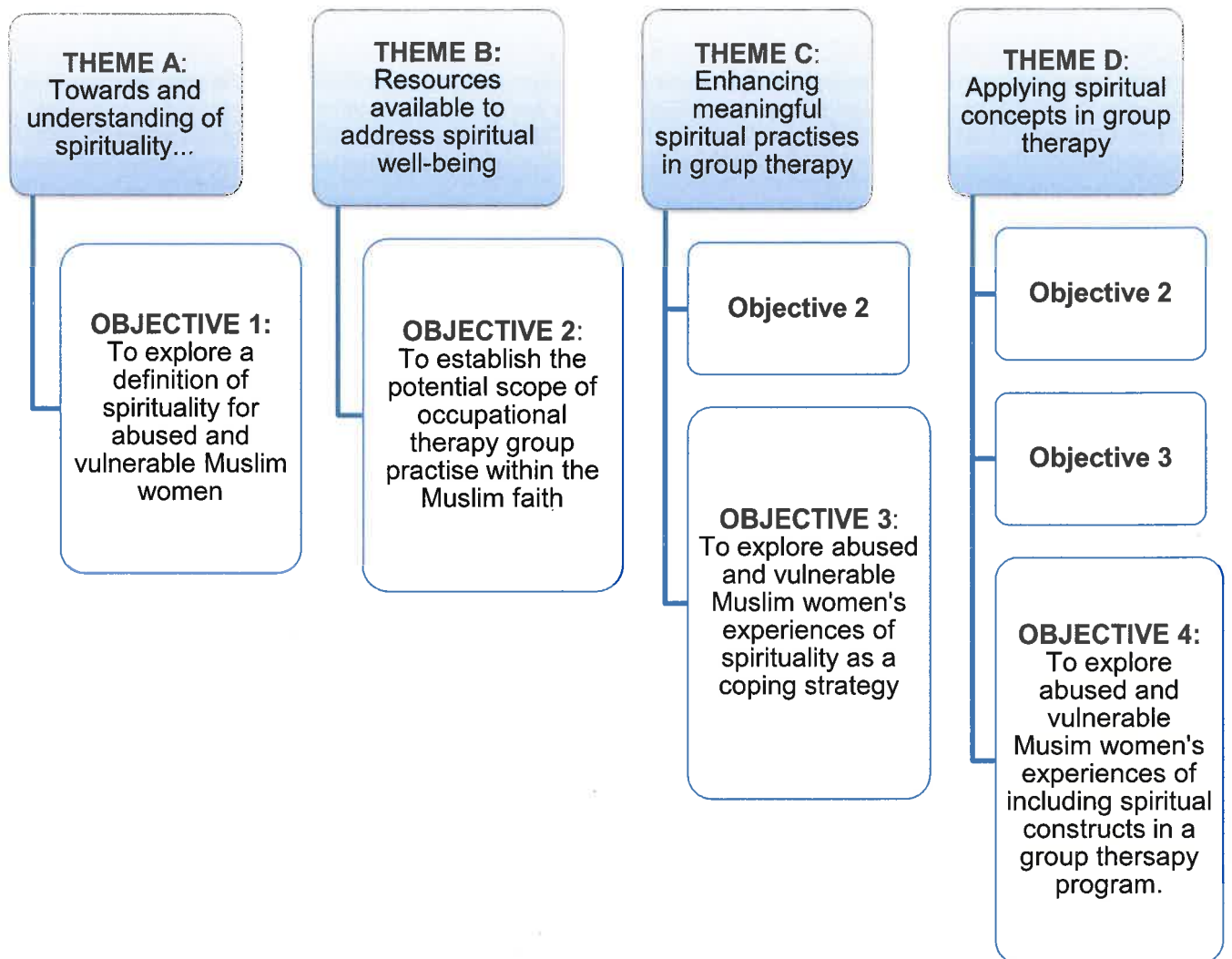


Figure 4.2 Diagram Linking Themes to Objectives

4.2 PARTICIPANT PROFILES

This section will introduce the participants through information obtained from the biographical section in the interview, and information obtained from clinical records at the Women's Centre. The researchers' observations during the group therapy program will also be described.

4.2.1 Hawa

Hawa is a 41 year old Indian female, who had no previous psychological intervention for her difficulties, and it was her first attendance at group therapy. She was referred

to the Women's Centre by a friend after a traumatic incident at her home. She reported the following as the reason for her residence at the centre:

"I lost my mum in December 2012... and I did something I was not supposed to do, and I got myself in some hot water. And I needed serious help. Actually I was raped and that's why I am here today."

Hawa was concurrently being treated for substance abuse at an out-patient rehabilitation centre, and embraced the group therapy process very quickly after her initial resistance. She had two previous marriages and two teenage children, and reported poor relationships with her parents, who were both deceased. Her brother and aunt were involved in her treatment at the Women's Centre.

4.2.2 Maryam

Maryam is a 48 year old White female who had converted to Islam three months prior to being admitted to the Women's Centre. She was referred by a social worker at a home for Muslim aged, where she was taken after converting to Islam. She had not received any psychological intervention previously, and it was her first attendance in a group therapy program. She reported the reason for her residence at the centre as follows:

"Basically, I was staying in a shelter before, where I was car-guarding, that's where men and women stayed under the same roof. It was about 120 people which is not always nice, and also I couldn't do namaaz (daily ritual prayer) or anything. Being a new Muslim I needed to know more about Islam and the teachings and everything."

Maryam reports further that her conversion to Islam came after she realised many signs, and felt that it was *"like Allah is calling me there."* She was also sentimental about her *"first cloak and scarf"* given to her by friends she had met while car-guarding. She was a keen participant of group therapy throughout, and expressed an interest in baking, crafts and business skills. Maryam had no family involvement while being a resident at the Women's Centre.

4.2.3 Amina

Amina is a Black 31 year Kenyan national. She had a 7 year old son with her at the Women's Centre. She had no previous psychological or group therapy intervention and was referred by a local Islamic welfare organisation. She reported the following as the reason for her residence:

"I am here because I had a problem with my ex-husband. I was living alone, we were separated since 2009, then 2011 we got divorced... But then he tried to make sure he messed up my job... He made sure he knows where I live... so he was trying to make sure that I don't have anybody around me."

She had resided with an aunt in Johannesburg but experienced the following:

"I never knew she had changed her religion, so when I reached, I was not allowed to read namaaz, ... She wanted to take me to church, so when I refuse she didn't like me. She was trying to convince me [to convert] and brought the pastor."

Amina had studied and taught Islamic studies in Kenya, and was looked upon by the residents for her perspectives on spiritual concepts mentioned in the groups. She had a keen interest in drama.

4.2.4 Khadija

Khadija is a 34 year old Indian female married to a foreign national and has 4 young children, who were sent overseas due to their marital difficulties. She reports having a history of suicidal ideations for which she had seen a psychologist but never attended group therapy. She was brought into the Women's Centre after being physically abused by her husband and she reported that the reason for her residence was:

"I was in an abusive marriage for about 11 years. It became a bit extreme whereby there was no other route to go. I had a few contacts, and managed to find myself here."

Khadija was out-spoken in groups, but demonstrated very low self-esteem. She expressed an interest in cooking and baking. She had telephonic contact with her

children, and no other family involvement. Khadija was settling her divorce matter in court at the time of the group therapy sessions.

4.2.5 Fatima

Fatima is 22 years old and of Nigerian origin. She arrived in South Africa on her own to study at tertiary level. She had no previous psychological or group therapy intervention. She was referred to the Women's Centre by a friend as she needed accommodation. She reports the reason for her residence as follows:

"I was having a problem with the students I was staying with. They were all Christians and so they don't understand my way of living...There was someone I got to know, who knew about the centre."

Fatima had not resumed her studying while at the Women's centre. She was a keen participant in group therapy and had a mature disposition. She had no family contact.

4.2.6 Ayesha

Ayesha is a 42year old South African Indian female of Muslim faith. She had seen a psychologist at a state facility individually, but had no family or group therapy intervention previously. She was brought to the Women's Centre by her sister, and reported the following as the reason for her residence:

"I don't have a place to stay...my parents are late... I was married and I lived with him for 15 years...and although we had our good days, he was abusive. He use to hit me with the belt... He said he wanted a child, but I said to him that I'm scared of failing pregnant."

Ayesha was a quiet group therapy participant. She responded only when asked a question and she used facial expressions minimally.

4.2.7 Rabia

Rabia is a 42 year old Muslim female from North West province. She consulted with a psychologist previously due to marital difficulties, but her husband refused to attend sessions when asked to join her. She was admitted at the Women's Centre

after being physically abused. She reports the reason for her residence as follows:
"I am here because I had an abusive relationship."

Rabia was a quiet group therapy member. She only responded when asked a question, and didn't make much self-disclosure. She was being treated concurrently for substance abuse at an out-patient rehabilitation facility.

4.3 THEME A: TOWARDS AN UNDERSTANDING OF SPIRITUALITY...

This theme is linked to Objective 1 of the study, which seeks to explore a definition of spirituality for abused and vulnerable Muslim women. Three sub-themes arose, namely a connection, to have faith and belief, and that spirituality is a source of help. These are represented in Figure 4.3.

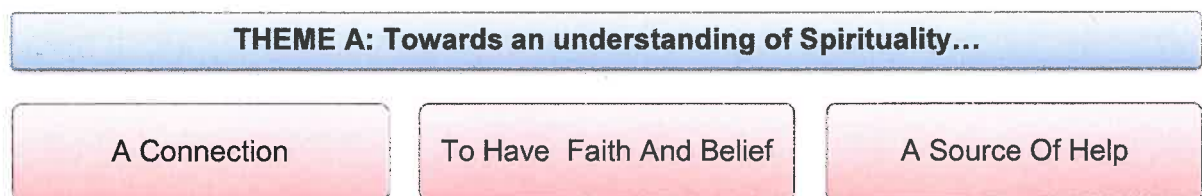


Figure 4.3 Theme A

4.3.1 A Connection *"Connecting with God. Connecting with yourself. And the universe."* (Maryam)

Six of the seven participants alluded to a spiritual connection with Allah, creating this sub-theme which includes meaning units relating to a connection, a relationship or a close-ness to Allah.

*"The stronger you build that connection, the stronger you will become ...
When I lost that connection I was weak, I couldn't concentrate, things got worse..."* (Khadija)

Maryam stated that the connection was universal, referring to a connection with all of creation, while others referred to a more personal relationship/link.

"How is your relationship with God. It's the way you find yourself being alone and talking to God." (Fatima)

Amina and Fatima alluded to closeness with Allah as a form of connection:

“He wants us to be close to Him, because He said He is closer to us than anyone [other creation]. Anyone can be close to Him if you choose to.”
(Fatima)

Hawa referred to the connection as a *“Powerful, energising force.”*

4.3.2 To have Faith and Belief: *“God... A spiritual being, and it’s somebody that we believe in, and He is up there.”* (Khadija)

In addition to a connection with Allah, four participants referred to a personal belief in Allah, which created hope and motivation for their future. This hope and motivation lead to strength and support for a better future. This faith and belief can be likened with a sense of meaning and purpose:

“[Spirituality] it’s like what you believe... and if you do believe then everything will come right... and when you believe, it gives you hope.”
(Rabia)

4.3.3 A Source of Help: *“I am trying to ask Allah to help me, I must go there...I will teach them through Allah.”* (Amina)

The participants related that Allah was there for them in many ways, and their examples were specific to their abusive or vulnerable situation. They described that belief was a precursor to gaining help from Allah. The help came in the form of support, guidance and strength.

“Ultimately you have to believe, I am a Muslim and I have to believe that there’s only one God, and that at the end of the day that God is there for us, that we have to worship Him because we are created by Him.”
(Ayesha)

Amina related that without Allah’s guidance, she may have been murdered, or forced to change her religion:

“If I wasn’t close to Allah, or if I didn’t know Allah... Maybe I would have been murdered... He helped me to move out of that lady’s house without accepting what she wanted me to do, Then I said Allah must keep guiding me through this.”

Khadija stated that she could have turned to drugs or alcohol, but turning to her musallah [prayer mat] gave her strength:

"I became weak for a moment, and then I said no He is out there...and He wants to see if I can get through this and be stronger... and instead of turning to drugs or alcohol I turned to my musallah and I did become stronger."

Textural description: Understanding spirituality from the perspective of abused and vulnerable Muslim women yielded a connection to Allah as utmost to all the participants. A connection, relationship or closeness to Allah was alluded to, which can be weakened by negative experiences, and also be strengthened. The connection was universal, a personal intrinsic journey, and a powerful, energising force that left one feeling 'alive again'. Participants referred to the need for faith and belief in one's spirituality, which together with a connection to Allah, can be assimilated to a sense of meaning or purpose. This ultimately leads to help in the way of guidance, strength and support from Allah.

Structural description: Participants experienced this connection through many cathartic moments during the group therapy process, which resulted in tearful eyes. They often prayed together and reminded each other that Allah did not and would not desert them in their time of need. A unified reawakening of hope ensued. The shift from a negative resistant attitude towards their creator to a positive and motivated connection was evident in their response to the topic.

Essence: During the period where the participant was subjected to abuse, the connection with Allah may have been weakened and questioned. Addressing spirituality, combined with group dynamics allowed the participants to apply this connection to their abusive circumstances and draw strength and resilience from spirituality, resulting in better coping, and improved occupational performance.

4.4 THEME B: RESOURCES AVAILABLE TO ADDRESS SPIRITUAL WELL-BEING

This theme correlates with Objective 2 of the study, which seeks to understand whether there is a role in occupational therapy groups for addressing spirituality within the Muslim faith. Three sub-themes arose, namely group therapy, clergy and other community resources. Participants compared the group therapy environment with talking to clergy or other resources, and related experiences from both scenarios. The sub-themes that emerged are represented in Figure 4.4.

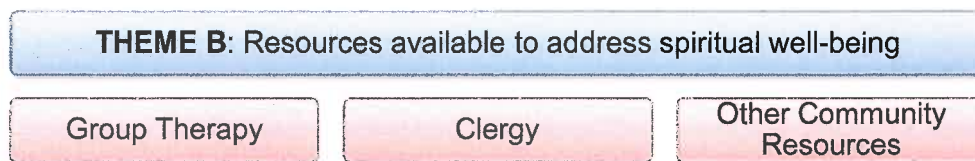


Figure 4.4 Theme B

4.4.1 Group Therapy: *"I find the group as a venue to bring hope, to bring help and to strengthen us more"* (Fatima)

All seven participants reported having positive feelings about addressing spirituality in the sessions, and found the group therapy process conducive to addressing spirituality. One reason cited by all participants, was that people shared opinions about spirituality, which generated different perspectives.

"In the group we have different people and different minds, so you get to talk, and when a question came about spirituality, from that answer other people can learn." (Amina)

"...to get other people's perspectives on various things, other people who you perhaps share something in common with. Even people who don't share anything with the counsellors, [they say] how they feel about it." (Maryam)

Fatima expressed that although group therapy dynamics helped solve her problems, spirituality was ultimately what helped.

"You can't do without being spiritual to help yourself, it's the spirituality that helps you to solve most of your problems easier compared to any other method."

Furthermore, addressing spirituality created a sense of meaning and belonging, and the group therapy discussions were internalised better, as participants believed in what was being said:

"If you are not spiritual, you can't believe in what you are doing. Even if you are trying to use the method of therapy, you still have to believe in it." (Fatima)

Participants also expressed the fact that having a group therapist who shared the same spirituality as them enhanced the cohesion of the group. One participant expressed it as being able to relate to the therapist, while Amina stated that she felt that it seemed like the therapist was *"on the same level as us."* She further explained that when the group spoke about spirituality she knew we were talking about *"our own Quran, which we know, and we talking about Allah who we know. It's not like I'm talking about Allah and you talking about Jesus."*

Rabia was not very expressive in the group sessions, but related that she would still attend, as she learned from what others said. In addition, she felt : *"It feels like [the therapist] is talking to me, and I can open up my problems. I feel very safe and secure. I find I can trust you."*

4.4.2 Clergy:

Participants were asked which they would prefer if they compared talking to a Moulana or Aalima (Islamic clergy) about spirituality and addressing it in group therapy. Rabia stated that she preferred talking to someone individually when addressing her personal problems, and hence was rather quiet in during the group sessions. Ayesha thought it was essentially the same. All five of the remaining participants agreed that they preferred talking in a group session and Hawa stated that she felt judged by clergy, while she sensed an environment of non-judgement in the group.

"They [clergy] also judged me, and I would not want someone to judge me. This way there is no judgement. We all speak and I know that no-one is being judged. We say what we want, our view or opinions, and we leave everything in that room." (Hawa)

Fatima felt that clergy were able to provide information and knowledge, while group therapy was able to address her emotional needs:

"When you want more knowledge, then maybe you can go to a Moulana, but in your own field, you [the therapist] are more aware of what is in there [the problem] The right person to meet while talking about a particular thing is the person in that field." (Fatima)

Maryam had a negative experience with Christian clergy:

"It's because when my mum died, and she was a very heavy Christian and went to church whenever she could, I just felt like they turned their back on me when I needed them." (Maryam)

Khadija thought that clergy lacked empathy, while the group members related well to what she said and felt:

"The difference was that when something was said, [in group] there was always two people who will relate to what I am saying; there was always someone who understood my pain and understood what I was trying to say. When you are talking to a Moulana, you are trying to convince him of how you are feeling, and no matter how much you explain, he is never going to understand." (Khadija)

Amina stated that religiously, Islam advocated seeking help from the right channels, and both clergy and therapists offered different modalities of treatment:

"The doctor is there, and the Moulana is there and both are important in life. When I am sick I will go a Moulana and he will recite Quran for me, but still the Prophet said 'Depend on Allah after taking the reason for depending', meaning take your panado, and now make dua. It's not that he [Moulana] can't cure us if he just prays, but He [Allah] is trying to show us that you need to work out for yourself about this, than just get help."

4.4.3 Other Resources

Participants also made reference to addressing spirituality with family members. Hawa describes her resistance to listening to her mum “preaching” due mainly to her anger, while Ayesha conversely describes her family as being well rooted in Islamic culture and values and learning from them.

Amina described fellow colleagues of Islamic studies, who she would not rely on to address spirituality, as their attitude toward her was negative:

“So until today they not talking to me... and they are fasting and they are Aalimas in Madrassa [college of Islamic education],, but I don't take sides. I said to be an Aalima is one thing, but to be a Muslim, that is something else.”

Three participants made reference to the residents at the home as a source of addressing spirituality, support and help. Ayesha spoke about assisting another resident by sharing a supplication that she had come across. Khadija and Hawa referred to sitting together evenings and having their own ‘therapy’ groups, particularly after performing their evening prayer together. They also engaged in reading Islamic literature, or group zikr.

Maryam had different needs met from residing at the Women’s Centre, being a place where she learned about Islam. She found that outside of group therapy, the residents at the centre took for granted that she understood religious concepts, whereas her situation meant that she didn’t. She therefore did not share the sentiment that the residents were a source of addressing spirituality outside of the group sessions.

Textural description: All participants agreed that group therapy was a good place to discuss spirituality. Five of the participants preferred addressing spirituality in group therapy to speaking with Islamic clergy, stating that clergy lacked empathy and were judgemental. Two participants said that clergy served the purpose of providing Islamic knowledge, but couldn’t relate that knowledge to real life circumstances that the women found themselves in. They possibly trusted the therapist as being skilled in dealing with their emotions, which is what they needed.

The combination of spirituality with group therapy meant they could apply their spirituality to their circumstances, which created change and coping.

Participants also spoke of other avenues to address spirituality, with family, members of the church, and peer residents at the Women's Centre being mentioned. Hawa expressed that she never listened to her mother, while Fatima and Ayesha said that their family were role models of spirituality. Maryam had negative experiences with the church, and did not feel they could support her. She also did not feel much support from the peer residents at the centre outside of group, expressing that they took for granted that she knew the culture and rituals and didn't take the time to teach her. However, all other participants expressed that the peer residents at the home were a good resource to address spirituality. They prayed together, had group discussions around spirituality and shared specific pieces of information that they thought would help each other.

Structural description: The group cohesion and positive dynamics were testament to the participants comfort and connection with addressing spirituality in group therapy. Change was facilitated by introducing spiritual concepts when dealing with emotionally charged issues. Participants who showed a resistance to discussing matters of spirituality were supported by the group therapy process, until a point of self-transformation and positive coping. Participants reflected disappointment and a loss of faith in resources where they have addressed spiritual issues in the past. Many positively emotive words and gestures were used to describe the phenomenon of addressing spirituality in group therapy.

Participants alluded to therapeutic factors that facilitated this change, including installation of hope and universality. Existential issues such as spirituality bringing participants closer to the ultimate source of help, and being in a position to combine meaningful activity with belief were mentioned. Spiritually charged didactic input in the form of verses of the Quran and prayers were offered. The group leaders handling skills brought a sense of trust and safety to the group participants, and empathy and non-judgement were felt, strengthening the group dynamic and facilitating application of skills learned into everyday life.

Essence: Occupational therapy groupwork is an empathetic and non-judgemental medium to address spiritual issues and facilitate application of the strength bearing principles to coping, empowerment and lifestyle.

4.5 THEME C: ENHANCING MEANINGFUL SPIRITUAL PRACTICES

This theme provides further insight into Objective 2, as well as directly addressing Objective 3 stated as to explore abused and vulnerable Muslim women's experiences of spirituality as a coping strategy. Participants made many reference to how the group therapy program had facilitated their ability to cope better and re-invented, or reminded participants of their existing spirituality. Participants also applied spiritual skills that were presented in the group, which reportedly assisted them with coping. Figure 4.5 represents the sub-themes that emerged from this theme.

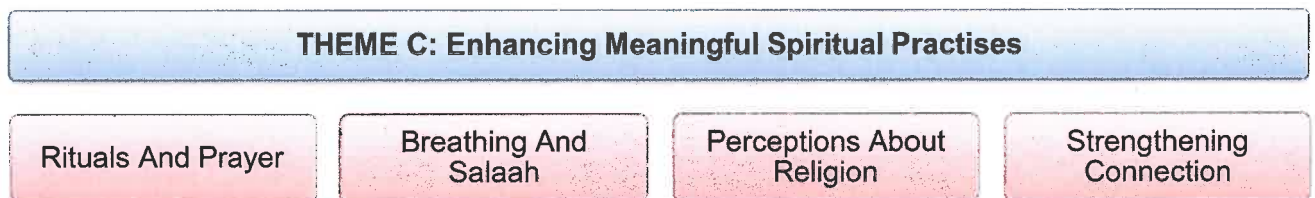


Figure 4.5 Theme C

4.5.1 Rituals and Prayer: *“Everytime we start with a prayer or with Allah’s name, it actually enhances how you feel.” (Hawa)*

Three participants made reference to the positive effect of using religious rituals and prayer as part of the group therapy process. Hawa describes a group session where we translated a short chapter of the Arabic Quran into English:

“I think ‘God, how am I going to translate this’ because I know how to read Arabic, but I don’t know the English version of it, and then somebody translated it for us, so I learnt so much and now I read my Quran in English because I need to know what I’m reading.”

The Islamic month of fasting, Ramadaan and the festival of Eid coincided with the period during which the sessions took place. Maryam, being a new Muslim really enjoyed a discussion on the festival of Eid:

“...That felt good, it was a bit new. Christmas day I know all about, but I kept hearing [from residents outside the group] all the talking about outfits for Eid, and this and that happens. Instead of making things up for myself!”

Khadija made reference to the use of Prayer/ Dua (supplication to Allah):

“... The fact that you started with a dua, and ended with a dua; in our conversation, in our therapy there was always Allah that had come up, and so I thought to myself... surely this can bring me some kind of peace.”

4.5.2 Breathing and Salaah

Maryam had practised meditation previously, and found the breathing exercises during relaxation therapy meaningful. Fatima relates that she had never come across breathing exercises as we practised them in the group therapy sessions. They were beneficial, and she was still practising them. Hawa expressed that breathing had helped her feel energetic and that she used breathing techniques while performing her daily prayers.

4.5.3 Perceptions about Religion

Participants also related experiences when they spent time reflecting on spiritual issues addressed in group therapy, which helped them to change perceptions.

“Change of thought and attitude; just trying to look at things in a different way, from a different point of view, rather than the way you always do.”
(Maryam)

Hawa related an incident where her perception of spirituality had changed:

“With everything that happened in my life I blamed God. Suddenly I realised that I had problems, but it is not God. It is the choices that we make in life, And yes, we have problems but we cannot blame Allah for that.”

Khadija emphasised that although she didn't feel a connection to Allah, He was always there:

"...Then I realised that He was always there, all the time, even when I was crying at home about that abusive relationship and I was not reading [praying], it was the same feeling [of being connected to Him] that I felt then. So He was actually there. I disconnected."

Fatima related that she was reminded that Allah is always with her, and that her thoughts and ideas were from Him:

"It helped very, very well. When you sitting down and you thinking no one is connected to you, then [you remember] Allah. So building the habit of sitting alone and trying to think, and when something comes to you mind, it is the work of Allah."

4.5.4 Strengthening Connection

All participants reflected that their spiritual connection had been weakened during their difficulties, but addressing spirituality in the groups had helped them to restore this connection and find meaning or purpose. Khadija eloquently stated that she could *"see her destination, but the journey is a bit difficult"*. She further stated that the direct reference to Allah and to prayer had prompted the following reaction: *"When I went down, I started [praying] and I got peace of mind. So in a way the group sessions had brought me closer to my creator."*

She realised that the reason she engages in prayer when she feels negative, is to draw Allah close to her:

"This time, if anything gets me down, all I will do is to read my salaah, or anything else I can read... and it made me realise that I was doing this not to calm myself down, but because I needed that connection to Allah, and want Him very close to me."

Ayesha felt that having a stronger connection manifested in her praying more, and wanting to share her knowledge with others:

"It encourages me to read [pray] more, and we get together or zikr [meditation] also... whatever skills you [Ayesha] have, you are giving off to somebody else for the benefit of it, and to make them better people."

Hawa stated that strengthening her spirituality meant learning more about herself, and tearing down masks that she may have been wearing. Which she learned from attending the group therapy sessions:

"I found myself actually. I was lost, but I found myself, especially in group sessions... and I want to keep up my spirituality in this way because a lot of people don't know themselves. We have this mask on and I don't think it's fair to any individual. By doing your salaah, by doing your zikr, you really get to know yourself."

Fatima further explained that through breathing exercise, poetry and reflective journaling, she found strength:

"Like the breathing exercise, like the writing of the poem, like sitting down and thinking and writing whatever comes to your mind, that built me [up again]."

Textural description: Participants expressed that addressing spirituality in group therapy enhanced their existing spirituality, which may have been clouded by the negativity of their circumstances. Many participants reported having a negative attitude towards Allah during their difficult circumstances, which had changed to a more mature understanding. More specifically, they felt that saying a prayer at the beginning and the end of the session, mentioning Allah or reciting an English translation of the Quran, had renewed their awareness and faith in spirituality. They reported carrying over these rituals into their daily routine, resulting in a strengthened sense of connection to Allah, and a shift in perception towards their spirituality and their circumstances. The relaxation technique invoking the attributes of Allah and used during salaah was mentioned as a positive and impacting activity.

Structural description: Initially, a sense of anxiety accompanied addressing of spiritual matters, which quickly settled into more engaging involvement. Patients would eventually volunteer to pray, or offer advice on prayers and rituals that they thought would help each other. They practised relaxation techniques in their individual capacity, and reported sleeping better or being less stressed and angered.

During the interview they had expressed an awakening or realisation of the power of spirituality to transform their mind-set and their circumstances. In the safety of the group therapy environment, participants could explore their own sense of spirituality, and listen to other perspectives. They expressed that they also attained much peace and contentment from engaging in their rituals during after group therapy sessions.

Participants again made reference to existential issues which facilitated change when perceptions about religion were explored. Didactic input in the form of discussions about rituals and prayer featured highly, where participants were keen and willing to share information. Fatima mentioned imitation, which encouraged her to practise rituals discussed in group, and Hawa made significant change in her interpersonal relationships, where she became aware of masks.

Participants mentioned that the breathing exercise was a meaningful group, both spiritually, and as a coping tool. Group leader roles of processing and application were mentioned, whereby participants reflected on lessons learned in group.

Essence: The processing and application of spiritual practises during the group sessions adds meaning for the participants and facilitates carry over of skills learned into everyday life. Addressing existential issues in group therapy facilitated change in perception and post traumatic coping. Strength was gained from a renewed sense of faith.

4.6 THEME D: APPLYING SPIRITUAL CONCEPTS IN GROUP THERAPY

The group therapy program was designed to employ therapeutic techniques to assist the women to cope and become empowered after abusive circumstances. The aims of therapy included anger and forgiveness, positive thinking and expressing gratitude. Islamic spirituality was applied to these concepts, in the way

of verses from the Quran, saying of the Prophet and other Islamic literature, Participants reported an ease of applying these concepts when addressed through the medium of spirituality.

This theme further enhanced Objectives 2 and 3, and spoke directly to Objective 4, which sought to explore abused and vulnerable Muslim women's experiences of including spiritual constructs in a group therapy program. Figure 4.6 shows the three sub-themes that arose.

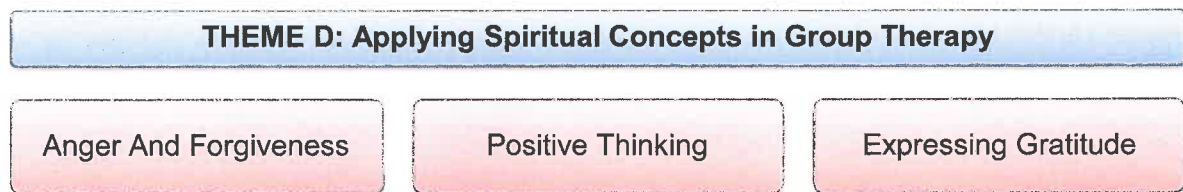


Figure 4.6. Theme D

4.6.1 Anger and Forgiveness

Hawa described a psychodrama session where she re-enacted a situation that was a source of anger for her. She was eventually able to forgive them in that emotional moment and she described the feeling as follows:

“I realised that I was also angry at my mum, and I needed to forgive her and also my dad, and lots of people around me. After that session, I went back and thought about a lot of things that I needed to work on.”

She further explained that forgiveness had helped her to experience a cathartic moment, and ultimately to cope:

“It had helped me to cope so much. Actually I don't think about the bad things that happened to me... I left that baggage because I sat on my Musallah [prayer mat], and I cried my heart out to Allah. I asked Him for forgiveness and I know that He has forgiven me.”

Rabia reported that addressing forgiveness impacted on her, and she realised that:

“You have to forgive, because Allah is the most forgiving, and as humans so are we. .. I am making my life right and I see [forgiveness] in a very different way now. Even my enemy, I have to forgive them.”

Amina described how she learnt to use spirituality to help curb her anger:

“Once you know who your Lord is, or who is your Allah, it’s easier. Then you know ‘now I am going to the wrong side’. When you get back that anger, you know you have to go back to Allah... I have learned this, and I know that Allah would like me to do this.”

Hawa expressed that prayer and zikr helped her to prevent anger outbursts:

“I notice that if I just say zikr a little bit, I am cleared [of the anger] and I have so much sabr (patience)... I can go the whole day without being angry. I am human, I do get angry, but I can control it now, and that’s by doing zikr...”

4.6.2 Positive Thinking

Fatima reported that she was able to practise positive thinking when faced with negative attitudes around her:

“Someone might come and tell you that you stupid and you don’t know what you’re doing; What I learnt in the group is that you don’t mind it, and that is what their opinion is, but you see it a different way, and that is part of spirituality... You know what is good for you, and Allah knows what is good for you too.”

Ayesha spontaneously remembered talking about positivity in group and for her it meant that: *“You have to look at life positively. You can look at what you can achieve and do with your life, and set some goals.”* Through this she was motivated to get involved in the activities offered at the centre.

Khadija saw a positive angle to her being admitted to the centre and away from her children:

“Then I sat back and I think; if my children were here I wouldn’t be at [this centre] and I wouldn’t be able to heal as a person... Sometimes I say Allah has reasons behind everything that happens.”

The group session on communication and assertiveness reportedly helped Maryam to have a better attitude towards people. She reported applying this skill to her previous job as a car guard, when she would be upset if people did not tip her, whereas now she realises that she did not understand their circumstances. She also applied this skill in her job interview a few days later. *“Overcome situations in a positive way. Instead of looking for the bad, you need to look for the good.”* She concluded by agreeing that this was a spiritual principle.

4.6.3 Gratitude

Khadija described how she learned to feel and express gratitude amidst the turmoil:

“I am very grateful that my creator, my Allah, kept me so strong in my heart and in my head, in his belief, that I had not taken to drugs or alcohol, that I had not taken to the wrong way of life, and that through all the trauma I still have the power to sit with my Musallah [prayer mat].”

She further explained:

“Sometimes we have little groups on our own downstairs...and it made me realise that Allah has really blessed me because some of the things that other women have gone through, I haven’t even been through half of that, and I thought my life was ending... and so I said thank you ALLAH for the problems you did give me.”

Textural description: Participants expressed that addressing spiritual constructs of anger and forgiveness, positive thinking and gratitude (represented as sub-themes in Figure 4.6) in group therapy sessions meant they could approach issues in a more mature and balanced manner. Perpetrators of anger from the past were forgiven, including the self, and Allah was invoked upon to facilitate this process. Future projections were infused with positivity, delivering a sense of hope and

motivation. Change in attitude and behaviour was prevalent within the dynamics of the Women's Centre and extended to their current personal circumstances.

Structural description: Participants engaged in the subject matter with much motivation and enthusiasm. They shared their reflections, expressing how it applied to them, and what would change in their outlook and behaviour. They were uninhibited in discussing spiritual matters, and invoked the names of Allah and His attributes, sayings of the Prophet Muhammad and other areas of spiritual learning during group therapy sessions. Body language was positive as they spoke of lessons that they had learned. Participants displayed a well-developed sense of self as they related experiences of the above spiritual constructs in their day to day tasks of living. Group dynamics alluded to included interpersonal learning, existential issues, and catharsis.

Essence: Forgiveness, positive thinking and gratitude as spiritual concepts, combined with group dynamics had impacted positively on participants coping and empowerment.

4.7 CONCLUSION

A wealth of information was obtained regarding the experiences of abused and vulnerable Muslim women on addressing spirituality whilst participating in occupational therapy groups. All participants expressed positive experiences of addressing spirituality and shift in perceptions that assisted with coping. This positive change was echoed by the social worker at the Women's centre, who reiterated that positive changes were noted in the overall atmosphere. The findings will be discussed further in Chapter 5.

CHAPTER 5. DISCUSSION

5.1 INTRODUCTION

Chapter 4 presented the themes that emerged from the study, with representative quotations from the participants. It was found that all participants had a positive experience of addressing spirituality in group therapy, and that their reasons for this were varied and vast. Participant's experienced better coping skills through applying the media offered in the group therapy sessions, and in some cases developed an understanding of spirituality which gave meaning and purpose to their situation. The chapter discussed the themes that emerged through thematic analysis and the objectives that they meet, as is graphically represented in Figure 4.2. Textural and structural descriptions, and an essence of the theme were offered.

Chapter 5 presents the discussion that will enable the research question to be answered, namely: *What are the experiences of abused and vulnerable Muslim women regarding the role of addressing spirituality within their therapeutic process?* This chapter will also highlight the application of the theoretical frameworks to the study. A graphic representation of the themes is presented in Fig 4.1, and the emergent themes will be discussed as sub-headings in this chapter, including discussion correlating findings with available literature. The research question, aims and objectives of the study will also be addressed here.

5.2 THEORETICAL FRAMEWORK

The CMOP-E (Polatajko et al., 2007) is a current model applied by occupational therapy departments throughout the world, and is progressive in including spirituality within the concept of human occupation, as outlined in Chapter 2. Although formal CMOP-E assessments were not used as part of this study, the model was applied to this study as a theoretical framework, due to its strong stance towards client centeredness, and towards spirituality being central to human occupation. Through this application, combined with the benefits of group dynamics, the gaps identified in the occupational performance of the participants have been addressed.

Participants may have been subjected to physical injury or illness, which would impact on the treatment plan and aims for therapy. More apparent however, will be

the affective and cognitive factors that will result from the various forms of abuse, including feelings of hopelessness, low self-esteem, negative thought patterns, and resentment, which could in turn affect spirituality negatively. Conversely, a strong sense of spirituality could impact positively on coping post trauma.

Cognition and affect were positively impacted upon through combining spirituality with group therapy. Thoughts were transformed from negative into more positive and constructive patterns that were underpinned by an awareness of Allah's help and support. A sense of strength in the participant's ability to cope was newly found. Forgiveness was seen as an attribute of Allah, which some participants were in need of, and others needed to practise. Forgiving thoughts replaced anger, which was cathartically expressed, impacting positive change on the affective level. Gratitude was always directed to Allah, and brought upon a realisation of positive constructs within their reach. Participant feedback throughout the group therapy duration ensured client centeredness of the approach, and participants reported feeling more energetic and motivated.

The interaction between the patient's spirituality and the trauma experienced by them, and the resultant impact on the individual's self-care, productivity and leisure pursuits, was addressed in a meaningful manner.

Participants reported that spiritual constructs were applied into their day to day functioning, and yielded positive results in relationships, vocation and problem-solving ability within the Women's Centre. Communication and behaviour improved in the physical environment of the centre. Some participants were placed in leadership positions, while others were able to secure employment. Initial resistance to attend group therapy soon gave way for more motivation and enthusiasm, strengthening group dynamics and facilitating application of skills into everyday lifestyle.

Islam has a set of values that dictate moral conduct, and abuse of any kind is not supported as part of Islam. However, there are institutions in Durban that would advocate the preservation of the marriage at any cost, and disallow the women from exercising her right to be respected, including dissuading her from divorce (Dangor,

2001; Hoel, 2012). This discouragement results in women having to find institutions that offer them the support they require to regain their sense of self, and often motherhood.

On an environmental level, group therapy intervention afforded participants the motivation to make constructive changes to their environment. Decisions were made regarding the current status of their home and their children. The spiritual environment at the Women's Centre played a positive role in allowing spirituality to be applied to occupational performance. Many were re-integrated into society after discharge, and directed to institutions that could further assist them, legally and socially.

The MMCM (Park, 2005) was also applied as a theoretical framework, as it described the process of coping post trauma through the individual appraising an event from a standpoint of an individual's global meaning system, including values and goals. The distress created by a disparity between appraised meanings of the event and the global meaning system could be reduced, by newly appraised and more constructive meanings formulated through intervention. Spiritual beliefs impact on both global meaning systems and the re-appraised meanings. Integration of these newly appraised meanings into global belief systems aid coping and limit distress.

As reported in Chapter 4, participants experienced transformation and change throughout the group therapy process, resulting in better coping skills. Participants first arrived at group therapy at the stage of distress, implying that appraised meanings of the event were not congruent with global belief systems. Motivation to participate was low and resistant attitudes were observed. Throughout the process of group therapy intervention, perceptions and feelings had changed towards a healthier outlook, and global meaning systems were altered to align positive meanings to the event, without compromising their right to constructive action.

Both theories applied to the context of this study can be seen as appropriate to the fields of trauma and spirituality within the Muslim population of Durban, South Africa. They should be applied to inform the process of addressing spirituality in

occupational therapy groups, specifically in the field of abused and vulnerable women.

5.3 THEME A: TOWARDS AN UNDERSTANDING OF SPIRITUALITY...

As shown in Figure 5.1, this theme is linked to Objective 1 of the study, which seeks to explore a definition of spirituality for abused and vulnerable Muslim women. Figure 4.3 displayed the three sub-themes that arose, namely a connection, to have faith and belief, and that spirituality is a source of help.

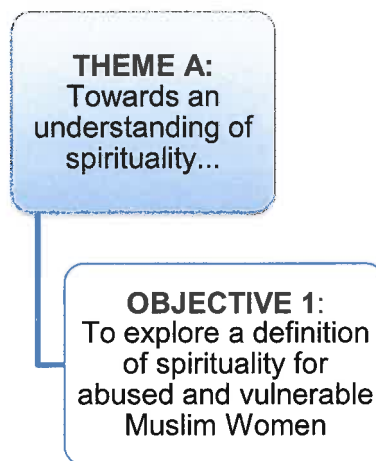


Figure 5.1 Theme A linked to Objective 1

Participants referred to the need for faith and belief in one's spirituality, which together with a connection to Allah, can be assimilated to a sense of meaning and purpose. This ultimately leads to help in the way of guidance, strength and support from Allah. Although there are innumerable constructs that may be included in a definition of spirituality, including love, peace, balance and wisdom, participants chose the words support, guidance and strength, which are all relative to their abusive and vulnerable circumstances: *"He [Allah] has not turned his back away from me."* (Khadija)

This shows that a definition of spirituality is a culture and meaning specific expression of the patient's needs, guided by personal, occupational and environmental circumstances. The CMOP-E has defined spirituality from a perspective of human occupation (Unruh et al., 2002) and placed it at the core of personal, occupational and environmental functioning. Fatima and Ayesha

confirmed this by stating that: “...without spirituality and belief, you cannot do anything... you have to have belief if anything is going to work.”

This quotation re-iterates the client-centeredness of placing spirituality at the core of occupational performance, although it has come under much scrutiny from peers. The CMOP-E’s definition of spirituality includes a meaningful connection and a source of will and self-determination. It also places the context of the environment, and is therefore applicable to abused and vulnerable Muslim women.

Many other definitions were suggested through publications, but these catered for the needs of a specific group of people or research design. Although subtle differences exist within these definitions, none of them can actually be termed incorrect (Schulz, 2005). Some definitions include connection to a higher being, but exclude a sense of meaning or purpose (Farah & McColl, 2008; Griffith, Caron, Desrosiers, & Thibeault, 2007), while others exclude the concept of help from a spiritual being (Janse van Rensburg et al., 2012; Schulz, 2005).

Given the participants’ history of abusive and vulnerable circumstances, the concept of help is vitally important to include into a definition for this group of participants. The Quran mentions in many verses that Allah is a source of help and guidance, and that for every hardship there will be ease (Pickthall, 1973). Applying a definition that includes the construct of help, as well as referring to verses of the Quran that highlight this, would render the group process client centered, and add meaning and value for the group members. In the words of Hawa: “*We were part of everything that happened in the group.*”

A team of healthcare workers have formulated a definition of spirituality within the South African context (Janse van Rensburg et al., 2012), which include a connectedness, and a sense of meaning or purpose, but omits a source of help, rendering it less applicable to this group of participants. In the absence of a standard definition, spirituality was defined for the purposes of this study as: *The nurturance of a connection with Allah, and its manifestation in ones meaning/purpose, coping, and empowerment.* This definition includes the concept of a connection, a sense of meaning and purpose, and coping and empowerment. Although the definition does

not include a source of help, it is assumed that that the help will ultimately lead to better coping and empowerment out of the abusive and vulnerable circumstances. This definition is therefore applicable to this group of participants. The direct reference to Allah makes the definition culture specific and meaningful.

Clinical practice of spirituality is dependent upon a definition, from which programs can emerge. According to the literature, a standard definition is still lacking in the field, which inhibits clinical practise (Simó-Algado et al., 2002; Udell & Chandler, 2000; Unruh et al., 2002). The question that has surfaced through the evolution of this study asks if a standard definition is a realistic expectation and a necessity for addressing spirituality in occupational therapy clinical practise?

Given the personal nature of the field, and the innumerable constructs that may be included in a definition, it is more reasonable that clinical application includes a discussion around the group members' understanding of spirituality, to establish one that speaks to the core of the individual and group process. Cornish and Wade (2010) describe 12 questions to facilitate discussions of spirituality in group counselling, which could be adapted to occupational therapy groups.

A standard definition may imply that a group member's personal understanding, which may deviate even slightly from the standard, will be incorrect theoretically. It may also lack specificity and meaning for the group. This could damage the integrity of the therapeutic relationship. Spirituality is also a personal and unique journey for group participants, which could alter the understanding of spirituality amongst groups of people with similar backgrounds at different stages of their lives.

In conclusion, a standard definition seems less necessary to the field of occupational therapy groupwork than an understanding of the participant's concept of spirituality, which can then be assimilated to a definition from the literature. This is in keeping with Teo (2009), who further states that it is less important to ask how we can apply spirituality than it is to accept the inherent spiritual nature of the profession.

5.4 THEME B: RESOURCES AVAILABLE TO ADDRESS SPIRITUAL WELL-BEING

Figure 5.2. shows that theme B correlates with objective 2 of the study, which seeks to understand whether there is a role in occupational therapy groups for addressing spirituality, according to group participants. Three sub-themes arose, namely group therapy, clergy and other community resources. Participants compared the group therapy environment with talking to clergy or other resources, and related experiences from both scenarios. The sub-themes that emerged are represented in Figure 4.4.

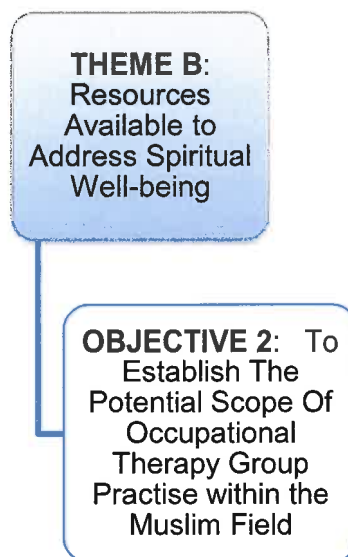


Figure 5.2: Theme B linked to Objective 2

Despite its recognition as a vital aspect of the total person (Polatajko et al., 2007; Schulz, 2005; Teo, 2009), a level of discomfort exists among therapists regarding applying spirituality in occupational therapy clinical practise (Cornish & Wade, 2010; Teo, 2009; Unruh et al., 2002). Conversely, and congruent with the findings of this study, it was found that patients express a level of comfort with, and a need to discuss spirituality with healthcare personnel (Azhar et al., 1994; Post & Puchalski, 2000; Schulz, 2005). The discomfort experienced by therapists should be dealt with as it prevents therapists from addressing spirituality, thus limiting holistic and client-centered service delivery (Mthembu et al., 2014).

Responses from participants confirm that group leader's empathetic, non-judgemental handling, sensitivity to the emotional well-being of the participation, and facilitation of spiritual matters into current circumstances made for fertile ground to speak about spiritual well-being and coping in occupational therapy groups. Student's perceptions of spiritual care are congruent with the above qualities highlighted by participants (Mthembu et al., 2015). Furthermore, participants confirmed that their experiences in addressing matters with clergy were highlighted by a lack of empathy, an air of judgement, a lack of information on psychological issues, and a lack in facilitating the application of spiritual matters to real-life situations.

Brody et al. (2004) describe a spiritual counsellor as one who: has an understanding of and is conversant with the biomedical aspects of a case (but not necessarily physicians); has training in psychology (but are not necessarily licensed psychologists); is skilled in the understanding of human relationships; is able to integrate the personal meanings of values for both themselves and their patients. In keeping with this, When applying this definition of a spiritual counsellor, it is noted that participants experiences of addressing spirituality with clergy has not satisfied these criteria, whilst the occupational therapist as the group leader did. A transdisciplinary approach including clergy into treatment programs may be a viable option (Human & Muller, 2015).

Addressing spirituality with family, colleagues and peer-residents was also shown to be less effective than group therapy, as participants expressed both positive and negative experiences of addressing spirituality with other resources. They listed anger towards and, a lack of support from family, a lack of integrity and trust with colleagues, and a lack of empathy and attention from peer-residents as reasons for not engaging in spiritual matters. They also listed a show of support and help from peer-residents, and a role-model within family as pre-cursors to engaging on spiritual matters.

CMOP-E and Occupational Therapy Framework for Practice (AOTA, 2002) are published and acknowledged models that confirm the inclusion of spirituality within the scope of practise of occupational therapy, yet therapists fear treading beyond

the scope of practise. Udell and Chandler (2000) identified the role of occupational therapy in addressing spirituality as being to meet practical spiritual needs and to acknowledge the patients spirituality with dignified treatment. According to the findings of this study, participants concurred that practical spiritual needs should be met, in this case to pray when the need arose during group sessions, and to be treated with empathy and non-judgement. Furthermore, they mentioned that the group sessions were more useful than speaking with clergy in that they facilitated better application of spiritual matters into their lifestyle.

The role of occupational therapy in addressing spirituality with abused and vulnerable Muslim women should therefore be expanded to include the following roles:

- a. **Understanding the spirituality of the patient:** During the orientation phase, the role of the occupational therapist must be outlined, and consent for the discussion must be obtained (Farah & McColl, 2008). Installation of hope as a therapeutic factor should also occur at this stage (Yalom, 2005). The participant's spiritual dimension should be assessed (Post & Puchalski, 2000) through standardised questionnaires, background interviews and functional assessments. Narrative therapy can also be applied, as information regarding what spirituality means to the patient including rituals and value systems can be sourced through narrative writing (Alers, 2010). The impact of spirituality on the patient's circumstances, or the incident's impact on the patient's spirituality, should be carefully assessed. Practical spiritual needs should also be assessed, for example the need for prayer (Farah & McColl, 2008).

- b. **Acknowledging the spirituality of the participant and the therapeutic relationship:** Information gathered from patients may not be in accordance with the therapist's perceptions of spirituality, but acceptance, empathy and non-judgement are group handling skills that the leader should be conversant with (Cornish & Wade, 2010). Universality (Yalom, 2005), will ensure that participants feel understood and accepted for their personal spiritual journey, strengthening the group dynamic. Spiritual constructs of respect and compassion should be enforced as a rule by the group leader. Further clarity

or research may be required in order to understand a participant's spirituality well enough to enhance meaningful service delivery (R Crouch, 2010).

- c. **A consultation with clergy:** Should the therapist be unsure of how to handle an aspect of the individual's spirituality, or how it impacts on his/her function, an appropriate clergyman should be consulted. Alternatively, should the clergy be involved in attending to spiritual matters with the patient, a transdisciplinary approach could be employed. Different sects of spirituality may also have differing perspectives on abusive situations, which should also be researched and understood as it may impact on the process of individual or group treatment (R Crouch, 2010). The client may also express the desire to consult with a clergyman.

- d. **Address practical spiritual needs:** These may include a desire to pray in solitude or as a group, visit a place of worship, fulfil a ritual or request spiritual materials. Fulfilling these practical needs should be part and parcel of occupational therapy.

- e. **Facilitate application of spirituality into lifestyle:** Application of lessons learned into daily life is a fundamental role of the group leader (Cole, 2012). The use of narrative therapy has shown to be effective in this regard (Kirsh, 1996). It should be determined whether an activity used in treatment and its application to the patient's lifestyle offers an inherent spiritual dimension (Hodge, 2005). It should be determined if the activity creates meaning and purpose and thereby strengthens a sense of faith and belief. One way of facilitating this process is to ask the open-ended question: "Is there anything spiritual about this activity for you?" and allowing the patient to reflect through writing or verbally. An environment receptive to practicing rituals has also been shown to facilitate application of spirituality into lifestyle and post-traumatic coping.

Therapists have expressed fear of addressing spirituality due to a potential transgression of patient-therapist boundaries (Unruh et al., 2002). During the course of training, students are moulded to assert healthy patient-therapist boundaries (Cornish & Wade, 2010). Occupational therapists are trained to apply non-judgement and empathy in deeply personal matters, for example sexual orientation or criminal activity. Occupational therapists are also urged to acquire mentorship and peer counselling where the potential for vicarious traumatising or transference exist, and to constantly reflect on their personal, internal journey. Dealing with spirituality should be no different.

In conclusion, given the participants positive experiences of addressing spirituality in group therapy, and considering the literature on the importance, scope and role of occupational therapy in addressing spirituality, it is important that spirituality be included in practical client-centred treatment. Barriers to addressing spirituality have been addressed in the literature review of this study, and found to hamper client-centeredness. In order to address some lack of skill and confidence that may be experienced by occupational therapists, training and discussion should be facilitated that could focus on the role of spirituality in occupational therapy groupwork. It is also very important to focus on patient-therapist boundaries, and media that are available to address this meaningful aspect of patients function.

5.5 THEME C: ENHANCING MEANINGFUL SPIRITUAL PRACTISES

As shown in Figure 5.3, this theme provides further insight into Objective 2, as well as directly addressing Objective 3 which is stated as to explore abused and vulnerable Muslim women's experiences of spirituality as a coping strategy. Participants made many reference to how the group therapy program had facilitated their ability to cope better and re-invented, or reminded participants of their existing spirituality. Participants also applied spiritual skills that were presented in the group, which reportedly assisted them with coping. Figure 4.5 represents the sub-themes that emerged from this theme.

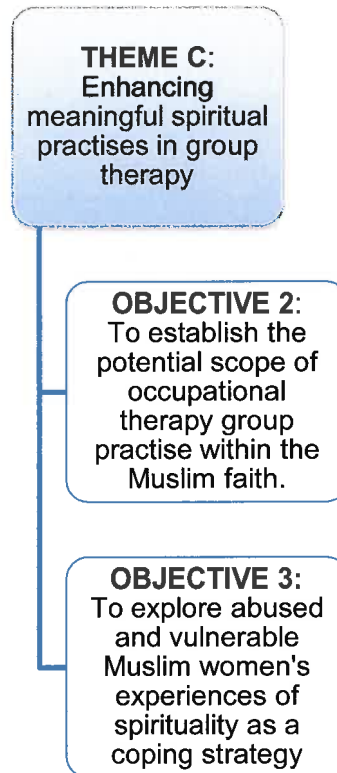


Figure 5.3 Theme C linked to Objectives 2 and 3

All of the participants had a strong Islamic value system prior to the traumatic events, due mainly to their family background and upbringing. During their traumatic events, many had turned away from Allah in anger, questioning if He was really listening, or why He would have inflicted such disadvantages upon them. Kolk et al. (2007) state that a symptom of post-traumatic stress includes a loss of previously sustaining beliefs, which confirms the above finding. This finding is also similar to Murray-Swank and Pargament (2005), who recognised the need for restoring spiritual beliefs in sexually abused patients to aid in coping, and designed a program to transform negative images and feelings towards God into a sense of hope and strength.

The findings of this study are in agreement with much of the literature, as other studies have reflected that engaging in prayer and other rituals during group sessions had a lasting effect on the participants. Ebadi et al. (2009) found that prayer and religious duty facilitated coping in Iranians suffering the effects of war,

terming prayer a complementary therapy. Shaw et al. (2005) and Post and Puchalski (2000) highlight in their research that patients have expressed a desire for prayer during a time of illness, and they may ask the practitioner to pray for them. They further explain that having spiritual needs addressed by a practitioner is likely to have a positive effect on the illness outcome. When asked to pray, the practitioner should extend the invitation to the patient and listen respectfully as they pray.

In an occupational therapy group environment, engaging rituals and prayer would begin with an understanding of spirituality as expressed by the patients. Thereafter group members can be invited to pray at opportune moments, initiated by either the therapist or group members. Using prayer and rituals would strengthen the existential aspect of the group dynamic. It is important ethically, that the therapist does not lead the prayer, but rather listens respectfully and non-judgementally (Cornish & Wade, 2010; Mthembu et al., 2015). Murray-Swank and Pargament (2005) utilise spiritual affirmations and rituals in their program 'Solace for the Soul', which reportedly yields a heightened sense of hope and spiritual connection.

The relaxation exercise conducted during the group therapy session utilised visualisation combined with remembrance of the attributes of Allah mentioned in Arabic. During the interview, participants recalled connecting with the exercise as a means of heightening spirituality as well as coping with trauma. Again, an assessment of the patient's individual spirituality could allow the therapist to identify media and integrate spiritual concepts into a relaxation process.

Relaxation techniques were utilised in the group therapy sessions, which included the repetition of positive and meaningful phrases. Combined with passively disregarding intrusive thoughts, this practise is reported to heighten spiritual connectedness, and to improve illness outcomes of physical and mental health conditions (Anandarajah & Hight, 2001; Bermudez et al., 2013). Post and Puchalski (2000) state that hope may be mediated through ritual, meditation, music, prayer and caring relationships. Thus installation of hope as a therapeutic factor is enhanced.

Anger and disheartenment was transformed into a strengthened connection with Allah, and to their seeing Allah as a source of ultimate peace, support, and this yielded positive outcomes. According to the literature, enhancing spirituality or strengthening a spiritual connection, and making a commitment to spiritual goals catalyse post-traumatic growth and help a traumatised individual to find positive meaning to the incident (George et al., 2000; Shaw et al., 2005).

The latter is re-iterated by Carone Jr and Barone (2001) who state that spiritual beliefs provide order amongst the chaos. Post traumatic growth ascends with the realisation that God will love unconditionally, no matter how cruel the world is or how worthless you feel about yourself, and that God is a trustworthy refuge. (Carone Jr & Barone, 2001; George et al., 2000).

Alcoholics anonymous (AA) is a well-researched program of support for recovering substance abusers. Contact with the God of ones' understanding is a key feature of this program, and the group is known to enhance spiritual practises (Kelly et al., 2012). Solace for the Soul, an eight session program designed to incorporate spiritual connection in therapy with victims of sexual abuse (Murray-Swank & Pargament, 2005), and Dr Badri Rickhi's spirituality teaching program for depression (Moritz et al., 2011), both yielded heightened spiritual connection as a result of incorporating spirituality into mental health treatment.

As participants of this study also recorded feelings of heightened spirituality and connectedness after attending group therapy sessions, the findings are congruent with literature around the subject matter. Enhancing meaningful spiritual experiences within occupational therapy can be accomplished using the following media:

- a. **Crafts:** These activities can include applicable spiritual sayings, quotations from scriptures, prayers, art and design specific to that religion. With Muslim women, the researcher was able to assist the group in creating paintings with attributes of Allah inscribed on them in Arabic, calligraphy of their names in Arabic, bookmarkers and other ornamental objects with verses from the Quran inscribed on them. In addition, we began activities by invoking Allah's blessings.

- b. **Relaxation therapy:** These are particularly necessary in the context of trauma. Relaxation techniques used in this group therapy process incorporated Allah's attributes of Ya Wadud (Most Loving), Ya Salaam (Most Peaceful), Ya Latif (Most Kind and Gentle) Ya Razzaq (The Provider), Ya Qawi (Most strong) and Ya Shafi (The Healer). Similar methods could be appropriately applied to groups of patients subscribing to other sects of spirituality.

- c. **Psychodrama:** This is an intervention medium in psychiatry, where a trained therapist facilitates a group drama out of an emotionally charged topic of particular relevance to the group, with the aim of resolving the issue to a point of peaceful re-integration. The spirituality of the individual is vital to consider when facilitating a psychodrama technique. The drama can consist of specific rituals that the protagonist may desire to enact in order to resolve the issue at hand. The group may also be asked to reflect upon the topic from a spiritual angle.

- d. **Journaling and Reflection:** The practise of journaling is known to integrate left and right hemispheres of the brain, resulting in a flow of thoughts and emotions that has numerous benefits for the individual on an emotional level. One's spirituality can be explored and understood in a journal through reflections on thoughts, incidences, relationships and challenges, and asking the question: What does my spirituality say about it? Specific issues of forgiveness and anger can be explored the same way. A gratitude journal is a way of exploring positive experiences, and shifting a negative mind-set to a more positive space. Prayers and reflections of verses from the Quran and sayings of the Prophet Muhammad can be written down in a journal. Exercises in poetry or letter-writing can be effective media.

- e. **Community activities with the less-privileged:** The act of community service is a meaningful activity that facilitates a shift in perception from a victim mentality into an empowered individual who is able to impact positively

on the existence of another human being. Low self-esteem, poor motivation and negative thought patterns can be contained and reversed through mutually beneficial interactions with community organisations. Service to the community is seen as an activity that strengthens the connection with Allah, as it is pleasing to Him. Orphanages, youth groups, homes for the elderly and animal care units can be volunteered at or invited to interact with the home. Service to humanity is a meaningful act of high regard within all spiritual sects, and discussion should ensue regarding the spiritual aspect of this activity.

In conclusion, abused and vulnerable Muslim women experienced a strengthening of coping and empowerment skills through the integration of spiritual practises in occupational therapy groups.

5.6 THEME D: APPLYING SPIRITUAL CONCEPTS IN GROUP THERAPY

As shown in Figure 4.6, participants attached a greater sense of meaning to skills learned in group therapy, and reported an ease of applying anger and forgiveness, positive thinking and gratitude, when spirituality was incorporated into traditional therapeutic media. Figure 5.4 shows that this theme further enhanced Objectives 2 and 3, and spoke directly to Objective 4, which sought to explore abused and vulnerable Muslim women's experiences of including spiritual constructs in a group therapy program.

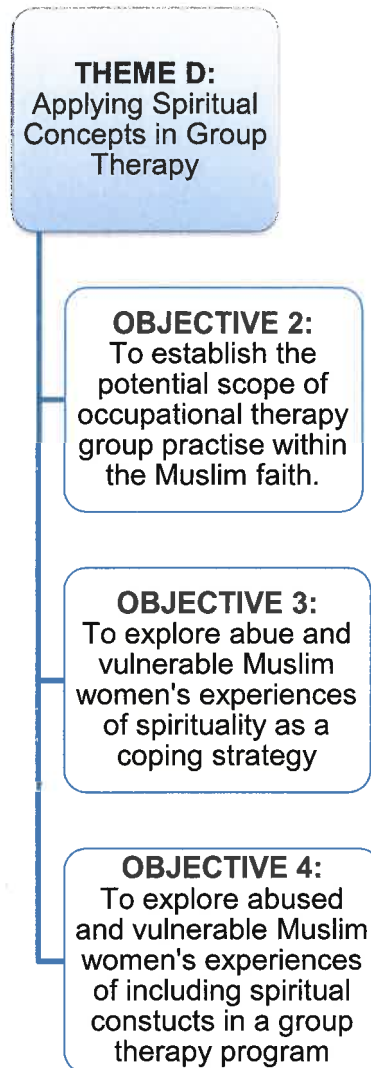


Figure 5.4 Theme D linked to Objectives 2, 3 and 4

According to the literature, forgiveness implies the giving up of anger and resentment towards a wrong-doer occurring in the context of a deep, personal and unfair hurt, and it is a process which is influenced by spiritual beliefs (Carone Jr & Barone, 2001; Sells & Hargrave, 1998). Participants affirmed this definition during group therapy sessions, where they were able to forgive perpetrators of abuse during their life-span. Acknowledging Allah as the most-forgiving catalysed this process of forgiveness, and the same sentiment was expressed in prayers for forgiveness upon the perpetrators. Participants also noted that turning towards spirituality assisted them to avert anger provoking situations.

Webb et al. (2012) confirm the link between forgiveness and spirituality, stating that in Islam, although retaliation is a viable option, forgiveness is among the highest

human virtues, and that this attribute of Allah should be emulated. Again, participants echoed this sentiment in their responses about addressing forgiveness in the group therapy sessions.

Cathartic and compassionate moments were features during the process of addressing forgiveness. Participants experienced a tangible difference in their cognition and mood from negative patterns to more constructive positive patterns. This is congruent with Webb et al. (2012) and Moritz et al. (2011), who note that compassion is an important step during the process of exercising forgiveness, which will lead to transformation of cognition from negative to positive thought patterns, and a calmer more peaceful mood.

Current programs reviewed in the literature express that addressing spirituality assisted in reducing negative images of God, and abandoning anger (Murray-Swank & Pargament, 2005) and that anger can be transformed into solidarity and love towards perpetrators of war (Simó-Algado et al., 2002). Findings of this study are therefore consistent with literature, and confirm that spirituality should be addressed in mental healthcare, which includes occupational therapy groupwork.

Articles and programs reviewed link coping with positive thinking, gratitude and hope (Moritz et al., 2011; Murray-Swank & Pargament, 2005). MacLeod and Conway (2007) and Linley and Joseph (2004) also found that positive affect, including acceptance, positive re-interpretation and positive religious coping were consistently associated with post traumatic growth. McEntee et al. (2013) state that spiritual maturity is an important aspect of human flourishing, and that love, joy, hope and gratitude are remnants of this maturity. McCullough, Emmons, and Tsang (2002) state that gratitude is a precursor to positive emotional experience and subjective wellbeing. The findings of this study confirm these sentiments with participants finding a positive and grateful perspective on various aspects of their current situation, including being admitted to the centre as a time for healing, having better circumstances than other residents at the Women's Centre, and maintaining their strength, spirituality and sanity.

Positive thinking stimulated motivation for the participants, driving them to seek employment and legal assistance, and building strength to continue. This is consistent with MacLeod and Conway (2007), who state that anticipating future positive outcomes is represented by striving for realistic valued goals, and McEntee et al. (2013) who state that human beings will flourish when spirituality aids positive nurturance and coping.

Participants acknowledged a divine interpretation to their circumstances and future, stating that Allah knew what was best for them, and that He has reasons behind everything that He does. This is consistent with Ebadi et al. (2009) who cited that perceptions of divine intervention played an important role as a coping mechanism post war.

Compassion as a spiritual construct was not overtly highlighted by any of the participants as one that they learned through group therapy to apply to their situations. Although threads of more compassionate attitudes and behaviour were evident throughout, compassion was not recognised as an independent entity that can be addressed in occupational therapy groups.

In conclusion, it is consistent with literature that the experience of applying spiritual principles of anger and forgiveness, positive thinking and gratitude yielded a strengthened sense of coping and empowerment for abused and vulnerable Muslim women when addressed in occupational therapy groups.

5.7 CONCLUSION

Chapter 5 discussed the themes that emerged through thematic analysis under separate sub-headings. Findings were discussed in the light of the literature reviewed, and the research question. Findings were shown to be consistent with literature around group dynamics and the client-centeredness of addressing spirituality, and offered constructive solutions to the barriers to addressing spirituality that have been posed in previous studies. Participants expressed that addressing spirituality in occupational therapy groups was a valuable tool in their coping and empowerment post abusive and vulnerable circumstances.

CHAPTER 6. CONCLUSION

6.1 INTRODUCTION

Abusive relationships continue to permeate all communities, despite religious and judicial legislature outlining prevention and punitive action towards the perpetrator. Although Muslim women in Durban have not been forthcoming to report cases of abuse, facilities have been established, including a Women's Centre with a spiritual ethos, to provide a place of safety and treatment for cases of abused and vulnerable Muslim Women that are reported.

Spirituality in mental healthcare has received much interest during the last decade, and is recognised as an essential element of human occupation. It is reported to have a positive influence on illness outcomes across mental healthcare, and research has documented positive effects of programs addressing spirituality on mental healthcare over a period of time. Patients also appreciate speaking about spirituality, and even praying with their practitioner.

Occupational therapy has also acknowledged the importance of spirituality to the functioning of the patient by including it in models and establishing the client-centeredness of addressing it with patients. However, research studies have not explored its application in clinical practise, or the client's perspective, resulting in much uncertainty and confusion amongst therapists on addressing spirituality in occupational therapy practise. In the absence of a standard definition, discussion with participants of a group therapy session should facilitate a meaningful understanding of spirituality for the group's specific needs.

Group dynamics have shown to be effective in the treatment of vulnerable populations, including women from abused and vulnerable circumstances. Yalom's therapeutic factors have shown to compliment strength bearing factors of spirituality. The group leaders handling of the group, which is inherently spiritual in its use of empathy and non-judgement, makes for efficient transition into applying spirituality into occupational performance areas.

In the absence of incorporating spirituality into a treatment regimen, the many beneficial outcomes that have been documented may not have been imparted to the patient, rendering therapy limited in its effect on human occupation. It is also important to consider the needs and perspective of the clients in lieu of conforming to client-centeredness. The aim of this study was to explore the positive experiences of Muslim women at a shelter for abused and vulnerable women regarding the role of addressing spirituality within their group therapy process.

This chapter will discuss and attempt to answer the research question and objectives of the study, and implications and significance of this study will be discussed in terms of curriculum planning, treatment and service delivery and health promotion. Limitations and future recommendations will then be discussed, followed by concluding remarks.

6.2 DISCUSSION

The research question was stated in Chapter 1 as what are the experiences of abused and vulnerable Muslim women regarding the role of addressing spirituality within their group therapy process? This study affirms that addressing spirituality with abused and vulnerable Muslim women facilitates coping and empowerment skills. It also affirms that addressing spirituality conforms to client-centeredness, should the client consider it meaningful and consent to discussing it. Coping skills that were presented in group therapy had a greater sense of meaning, when paralleled with spiritual concepts.

Objectives of the study were listed in Chapter 1 and are repeated below, followed by a discussion.

1. To explore a definition of spirituality for abused and vulnerable Muslim Women;
2. To establish the scope of occupational therapy group practise within the Muslim faith;
3. To explore abused and vulnerable Muslim women's experiences of spirituality as a coping strategy;

4. To explore abused and vulnerable Muslim women's experiences of including spiritual constructs, in a group therapy program.

Objective 1 of the study was met by extracting a clear understanding of what spirituality meant in the context of the abused and vulnerable Muslim women. This included a connection to Allah, a sense of faith and belief, and that spirituality was an indispensable source of help.

Objective 2 was met by participants being in agreement that it was a positive experience to address spirituality in group therapy, and that their sense of commitment and motivation to attend group therapy had increased, from being disinterested, to taking ownership of the process. Most had clearly thought it a more appropriate avenue to discuss and relate spirituality to their current circumstances, than to speak with clergy, family or other residents at the Women's Centre. These results speak to the client-centeredness of addressing spirituality in occupational therapy groups, and say that the participants derived enormous benefit in terms of coping, empowerment, and function, which would render it within the scope of the occupational therapy groups.

Both Objectives 2 and 3 were met by participants confirming that practising spiritual rituals and prayer had immediately impacted on their sense of meaning and purpose deeply, and enhanced their experience of group therapy. They also practised their rituals more often outside of group, from which a great sense of comfort was derived. Relaxation techniques and breathing exercises incorporated the attributes of Allah and postures of salaah, which was noted by many participants as beneficial. Through addressing spirituality they shifted their perspectives from one of anger, to one of hope and strength, which resulted in strengthening their connection to Allah, and coping with their abusive circumstances more constructively.

Objectives 2, 3 and 4 were addressed when participants reported applying the concepts of anger management and forgiveness, positive thinking and gratitude into their daily living, which resulted in a balanced experience of life. Anger was resolved using forgiveness and introspection, positive thinking impacted greatly on

communication and job-seeking, and participants were able to express gratitude that their circumstances were not any worse, and that they had sought help.

The results obtained conform to the literature reviewed on the subject, and other programs addressing spirituality seemed to yield similar results. Findings of the study challenged perceived barriers to applying spirituality in occupational therapy, and a pathway to better implementation of spirituality in group therapy was discussed.

6.3 SIGNIFICANCE AND IMPLICATIONS OF THE STUDY

Spirituality is being recognised through research as a vital factor of occupational performance that needs to be addressed in mental healthcare, and its application may have far reaching implications for patient's well-being. This study could be significant in the field of occupational therapy groupwork, as it yields results on the perspective of the patient on addressing spirituality. In South Africa it is one of few occupational therapy articles around the topic of spirituality. It is also the first occupational therapy study to be done on a population of Muslim women. It is intended that much interest about spirituality will be gained in occupational therapy groupwork in South Africa through publication and presentation of this paper.

Due to scarcity of literature, and the lack of attention to the field at present, a large population of occupational therapy patients are not afforded the opportunity to explore their spirituality as a factor affecting their occupation. To merge traditional occupational therapy service delivery with the spirituality of the patient may create a more meaningful experience for the patient, and better compliance to a lifestyle of constructive function. It is hoped that this research will pave the way for more research, discussion and learning around the subject, leading to application into clinical practise of occupational therapy. Implications for the study extend to curriculum development, treatment and service delivery and health promotion.

- a. **Curriculum development:** It was noted in the literature review that therapists did not feel trained enough to address spirituality in clinical practice, and that a course that was offered at university was not well attended. It is important to initiate the process of including coursework on

addressing spirituality by reviewing the curriculum and developing a module at undergraduate level. Post-graduate research on the topic and introspection on the role of spirituality in practise should be encouraged at tertiary level, extending to all field of mental healthcare. Trans-disciplinary treatment including theologians and clergy should also be discussed.

- b. **Treatment and service delivery:** As discussed in Chapter 2 and confirmed in Chapter 4, the application of spirituality in occupational therapy groupwork has far-reaching benefits for the patient's mental health and well-being. Particularly in the field of abuse and vulnerable populations, spirituality has a vital role to play in facilitating post-traumatic coping. Workshops with practising occupational therapists can be organised to discuss addressing spirituality in practise, and dispel perceived barriers. Again, this impact may extend towards other areas of occupational therapy practise, including individual and group physical and psychiatric practise, and eventually to other faculties of mental healthcare. Evidence based research should document the findings of such implemented programs.

- c. **Health promotion:** Given the statistics on domestic violence and abuse, prevention programs are ultimately necessary and occupational therapy has a role to play in that field. Many institutions have begun to deal with prevention of domestic violence, and empowering groups of people to speak up, for themselves and others. Prevention in Action is one such organisation, which encourages groups of people to work together in combatting domestic violence. Occupational Therapy groupwork can facilitate discussions on real issues of social injustices and inequities in the communities, including spiritual aspects of domestic violence, seeking justice and speaking up for those oppressed.

6.4 LIMITATIONS OF THE STUDY

Although every effort was made to minimise confounding variables in analysing this study, three possible limitations to the study were identified, and will be discussed hereunder, including methods employed to minimise them.

- a. The interview schedule: The interview schedule contained questions and listed prompting questions, or salient points around the questions, in order to gain a full understanding of the phenomenon, and answer the research question. The use of prompting questions may have directed the interview too much, and were therefore only used when the researcher noticed that the questions were not being comprehensively answered.
- b. Inductive vs Deductive reasoning: The study was designed as a phenomenological study, which uses primarily inductive reasoning to extract an essence of the phenomenon being understood. This study combined inductive and deductive reasoning in an effort to gain information regarding specific points that require further clarity according to the literature. A definition of spirituality and a preference to speak with clergy were established deductively.
- c. The Hawthorne effect (Leonard & Masatu, 2006) may have impacted on the research process, as the researcher was also the group therapist. This is considered a major flaw and should be avoided in future studies. There was an attempt to minimise this effect by establishing with participants that the researcher was open to negative feedback in order to gain an honest and comprehensive understanding of the subject, and by affirming confidentiality and anonymity. The trust of the participants in terms of discussing spiritual matters was paramount to being able to conduct this study.

6.5 RECOMMENDATIONS

The field of spirituality in mental healthcare is fairly new, and much groundwork is required to establish it in clinical practise. This study highlighted areas wherein the process can be initiated. Recommendations from this study will be discussed in relation to implications listed in 6.3 above.

6.5.1 Curriculum development:

- a. Replicating this study: It is recommended that this paper be replicated in other fields of occupational therapy group and individual practise, with individuals who subscribe to different sects of spirituality, leading to a

paper addressing a universal concept of spirituality that can be applied to a heterogeneous group of participants. Limitations should be effected in replications.

- b. Other research areas: Spirituality is a fairly new field in mental healthcare, and opportunities for research are boundless. Research can address the perspective of the therapist, departments, and patients in individual or group settings in all areas of clinical practise. Research on applying spirituality is much needed at present.
- c. Preparing a teaching module on spirituality: It is recommended that all occupational therapy departments develop a module on addressing spirituality at undergraduate level. The module should include introspections of the student on their own spiritual journey through a portfolio and working groups where their personal journey is shared. The theoretical component should include a review of the history of spirituality in mental healthcare, theoretical models and frameworks, clinical applications, therapist facilitation and handling, perceived barriers and tools and modalities available. A practical should also be included in the mark allocation. Supervision for the therapist/student in terms of spiritual matters is essential.

6.5.2 Treatment and service delivery:

- a. Occupational Therapy Associations: All communities of practising occupational therapists belong to a body that regulates ethical and practise related issues. These bodies should also be mobilised regarding the inclusion of spirituality in clinical practise, so as to exclude any unethical practise. The Canadian Association of Occupational Therapy (CAOT) was involved in publications and policy documents to implement spirituality into practise models. The Occupational Therapy Association of South Africa (OTASA) is one such body in South Africa. This should be the first stage of planning and implementing a program to address spirituality in occupational therapy.

- b. Practising Occupational Therapists: All practising therapists are required to obtain continuing professional development portfolios. Spirituality can be presented at such forums, conferences and workshops. Theory and current research can be presented, and a discussion forum should be established. Mentorship programs should also address spiritual issues with practising occupational therapists.
- c. Abused and vulnerable populations: Treatment facilities for abused and vulnerable populations should be located and discussion should ensue regarding the role of occupational therapy groups in the treatment of patients. The role of spirituality in addressing trauma should also be outlined, and a program of intervention aimed at coping and empowerment should be discussed. On a macro level, proactive prevention campaigns can be networked with legal personnel, policy-makers and clergy to address social injustices and address inequities.
- d. The trans-disciplinary team: Other members of the healthcare team and the facility should be made aware of the scope and the therapists planned intervention. The team should be made aware of their role in addressing spirituality, and research should be highlighted. Any concerns regarding the application of spirituality should be openly discussed. A program of including clergy and theologians in to the team of mental healthcare workers is necessary.

6.5.3 Health Promotion

Organisations committed to prevention of domestic violence should be consulted on the potential contribution that occupational therapy groups can make to empowering communities to speak out against perpetrators. Occupational Therapy groupwork can address social injustices by networking community based stakeholders with policy-makers, prevention campaigns, clergy and legal personnel.

6.6 CONCLUSION

In conclusion, a quote from the twelfth century Sufi poet, Jalaluddin Rumi, is appropriate. He is considered a sage of the time, and his writings have grown in popularity through the centuries (Harvey, 2013). The quotations speak to empowerment and healing, and offer much support and comfort to the vulnerable in spirituality.

“Learn the alchemy true human beings know. The moment you accept what troubles you’ve been given, the door will open.”

“Try not to resist the changes that come your way. Instead, let life live through you. And do not worry that your life is turning upside down. How do you know that the side you are used to is better than the one to come?”

“I said: What about my eyes?”

God said: Keep them on the road.

I said: What about my passion?”

God said: Keep it burning.

I said: What about my heart?”

God said: Tell me what you hold inside it.

I said: Pain and sorrow

God said: ...Stay with it. The wound is the place where the Light enter you.”

(Harvey, 2013).

REFERENCE LIST

- Alers, V. (2010). Working with trauma survivors - from victim to trauma survivor to thriver. In R. Crouch & V. Alers (Eds.), *Occupational Therapy An African Perspective* (pp. 268-285). Johannesburg: Sarah Shorten Publishers.
- Anandarajah, G., & Hight, E. (2001). Spirituality and medical practice.
- AOTA. (2002). *Occupational therapy practice framework: Domain & process*: Amer Occupational Therapy Assn.
- Azhar, M. Z., Varma, S. L., & Dharap, A. S. (1994). Religious psychotherapy in anxiety disorder patients. *Acta Psychiatrica Scandinavica*, *90*(1), 1-3. doi: 10.1111/j.1600-0447.1994.tb01545.x
- Bermudez, D., Benjamin, M. T., Porter, S. E., Saunders, P. A., Myers, N. A. L., & Dutton, M. A. (2013). A qualitative analysis of beginning mindfulness experiences for women with post-traumatic stress disorder and a history of intimate partner violence. *Complementary Therapies in Clinical Practice*, *19*(2), 104-108. doi: <http://dx.doi.org/10.1016/j.ctcp.2013.02.004>
- Borneman, T., Ferrell, B., & Puchalski, C. M. (2010). Evaluation of the FICA tool for spiritual assessment. *Journal of pain and symptom management*, *40*(2), 163-173.
- Brody, H., Cardinal, J. L., & Foglio, J. P. (2004). Addressing spiritual concerns in family medicine: a team approach. *The Journal of the American Board of Family Practice*, *17*(3), 201-206.
- CAOT. (1991). *Occupational therapy guidelines for client-centred practice*: Canadian Association of Occupational Therapists.
- Carone Jr, D. A., & Barone, D. F. (2001). A social cognitive perspective on religious beliefs: their functions and impact on coping and psychotherapy. *Clinical Psychology Review*, *21*(7), 989-1003. doi: [http://dx.doi.org/10.1016/S0272-7358\(00\)00078-7](http://dx.doi.org/10.1016/S0272-7358(00)00078-7)
- Chittick, W. C. (2007). *The Inner Journey: Views from the Islamic Tradition*.
- Coetzee, S., & Viviers, R. (2007). An overview of research on positive psychology in South Africa. *South African Journal of Psychology*, *37*(3), 470-490.
- Cole, M. B. (2012). *Group dynamics in occupational therapy*: SLACK INCORPORATED.
- Collins, M. (1998). Occupational Therapy and Spirituality: Reflecting on Quality of Experience in Therapeutic Interventions. *The British Journal of Occupational Therapy*, *61*(6), 280-284.
- Constitution. (2011). *Constitution of the Republic of South Africa, 1996*.
- Cornish, M. A., & Wade, N. G. (2010). Spirituality and religion in group counseling: A literature review with practice guidelines. *Professional Psychology: Research and Practice*, *41*(5), 398.
- Craig, C., & Mountain, G. A. (2007). *Lifestyle matters: An occupational approach to healthy ageing*: Speechmark.
- Creswell, J. W. (2012). *Qualitative inquiry and research design: Choosing among five approaches*: Sage publications.
- Crouch, R. (2010). The relationship between culture and occupation in Africa. In R. Crouch & V. Alers (Eds.), *Occupational Therapy An African Perspective* (pp. 50-59).
- Crouch, R., & Alers, V. (2014). *Occupational therapy in psychiatry and mental health*: John Wiley & Sons.
- Dangor, S. (2001). Historical perspective, current literature and an opinion survey among Muslim women in contemporary South Africa: A case study. *Journal of Muslim Minority Affairs*, *21*(1), 109-129.
- Douki, S., Nacef, F., Belhadj, A., Bouasker, A., & Ghachem, R. (2003). Violence against women in Arab and Islamic countries. *Archives of Women's Mental Health*, *6*(3), 165-171. doi: 10.1007/s00737-003-0170-x
- Ebadi, A., Ahmadi, F., Ghanei, M., & Kazemnejad, A. (2009). Spirituality: a key factor in coping among Iranians chronically affected by mustard gas in the disaster of war. *Nursing & Health Sciences*, *11*(4), 344-350. doi: 10.1111/j.1442-2018.2009.00498.x

- Echeburúa, E., Sarasua, B., & Zubizarreta, I. (2013). Individual versus individual and group therapy regarding a cognitive-behavioral treatment for battered women in a community setting. *Journal of interpersonal violence*, 0886260513511703.
- Farah, J., & McColl, M. A. (2008). Exploring prayer as a spiritual modality. *Canadian Journal of Occupational Therapy*, 75(1), 5-13.
- Fereday, J., & Muir-Cochrane, E. (2008). Demonstrating rigor using thematic analysis: A hybrid approach of inductive and deductive coding and theme development. *International journal of qualitative methods*, 5(1), 80-92.
- Galvaan, R., Peters, L., Smith, T., Brittain, M., Menegaldo, A., Rautenbach, N., & Wilson-Poe, A. (2015). Employers' experiences of having a live-in domestic worker: Insights into the relationship between privilege and occupational justice. *South African Journal of Occupational Therapy*, 45(1), 41-46.
- George, L. K., Larson, D. B., Koenig, H. G., & McCullough, M. E. (2000). Spirituality and health: What we know, what we need to know. *Journal of social and clinical psychology*, 19(1), 102-116.
- Gibson-McCrory, D., & Upchurch, D. (2015). Treatment of women and domestic violence in Africa. 4(1 & 2), 57-69. Retrieved from http://reference.sabinet.co.za/webx/access/electronic_journals/aa_jgida/aa_jgida_v4_n1_2_a5.pdf
- Gorde, M. W., Helfrich, C. A., & Finlayson, M. L. (2004). Trauma symptoms and life skill needs of domestic violence victims. *J Interpers Violence*, 19(6), 691-708.
- Graneheim, U. H., & Lundman, B. (2004). Qualitative content analysis in nursing research: concepts, procedures and measures to achieve trustworthiness. *Nurse education today*, 24(2), 105-112.
- Griffith, J., Caron, C. D., Desrosiers, J., & Thibeault, R. (2007). Defining spirituality and giving meaning to occupation: The perspective of community-dwelling older adults with autonomy loss. *Canadian Journal of Occupational Therapy*, 74(2), 78-90. doi: 10.2182/cjot.06.0016
- Harvey, A. (2013). *The way of passion: A celebration of Rumi*: North Atlantic Books.
- Hassouneh-Phillips, D. (2003). Strength and vulnerability: Spirituality in abused American Muslim women's lives. *Issues in mental health nursing*, 24(6-7), 681-694.
- Hess, K. Y., & Ramugondo, E. (2014). Clinical reasoning used by occupational therapists to determine the nature of spiritual occupations in relation to psychiatric pathology. *The British Journal of Occupational Therapy*, 77(5), 234-242.
- Hodge, D. R. (2005). Social work and the House of Islam: orienting practitioners to the belief and values of Muslims in the United States. *Social Work*, 50(2), 162-173. doi: 10.1093/sw/50.2.162
- Hoel, N. (2012). Engaging religious leaders: South African Muslim women's experiences in matters pertaining to divorce initiatives. *Social Dynamics*, 38(2), 184-200. doi: 10.1080/02533952.2012.717207
- Hojat, M., Gonnella, J. S., Nasca, T. J., Mangione, S., Vergare, M., & Magee, M. (2002). Physician empathy: definition, components, measurement, and relationship to gender and specialty. *American Journal of Psychiatry*, 159(9), 1563-1569.
- Human, H., & Muller, J. C. (2015). Sexual abuse : a practical theological study, with an emphasis on learning from transdisciplinary research : original research. 71(3), 1-10. Retrieved from http://reference.sabinet.co.za/webx/access/electronic_journals/hervorm/hervorm_v71_n3_a81.pdf
- <http://dx.doi.org/10.4102/hts.v71i3.3025> doi:<http://dx.doi.org/10.4102/hts.v71i3.3025>
- Ibrahim, N., & Abdalla, M. (2010). A critical examination of Qur'an 4: 34 and its relevance to intimate partner violence in Muslim families. *Journal of Muslim Mental Health*, 5(3), 327-349.

- Janse van Rensburg, B., Poggenpoel, M., Myburgh, C. H., & Szabo, C. (2012). A Model for the Role of Defined Spirituality in South African Specialist Psychiatric Practice and Training. *Journal of Religion and Health*, 1-20. doi: 10.1007/s10943-012-9644-3
- Kelly, J. F., Hoepfner, B., Stout, R. L., & Pagano, M. (2012). Determining the relative importance of the mechanisms of behavior change within Alcoholics Anonymous: a multiple mediator analysis. *Addiction*, 107(2), 289-299. doi: 10.1111/j.1360-0443.2011.03593.x
- Kielhofner, G. (2007). *Model of Human Occupation: Theory and Application*: Lippincott Williams & Wilkins.
- Kirsh, B. (1996). A Narrative Approach to Addressing Spirituality in Occupational Therapy: Exploring Personal Meaning and Purpose. *Canadian Journal of Occupational Therapy*, 63(1), 55-61. doi: 10.1177/000841749606300107
- Kirsh, B., Dawson, D., Antolikova, S., & Reynolds, L. (2001). Developing awareness of spirituality in occupational therapy students: Are our curricula up to the task? *Occupational therapy international*, 8(2), 119-125.
- Kolk, B. A. v. d., McFarlane, A. C., & Weisaeth, L. (Eds.). (2007). *TRAUMATIC STRESS: The Effects of Overwhelming Experience on Mind, Body, and Society*. NEW YORK: THE GUILFORD PRESS.
- Leonard, K., & Masatu, M. C. (2006). Outpatient process quality evaluation and the Hawthorne Effect. *Social science & medicine*, 63(9), 2330-2340.
- Lewis, B., & Pellat, C. (1982). *The encyclopaedia of Islam*: Brill.
- Lietz, C. A., Langer, C. L., & Furman, R. (2006). Establishing Trustworthiness in Qualitative Research in Social Work Implications from a Study Regarding Spirituality. *Qualitative Social Work*, 5(4), 441-458.
- Linley, P. A., & Joseph, S. (2004). Positive change following trauma and adversity: A review. *Journal of Traumatic Stress*, 17(1), 11-21.
- MacLean, C. D., Susi, B., Phifer, N., Schultz, L., Bynum, D., Franco, M., . . . Cykert, S. (2003). Patient Preference for Physician Discussion and Practice of Spirituality. [Article]. *JGIM: Journal of General Internal Medicine*, 18(1), 38-43. doi: 10.1046/j.1525-1497.2003.20403.x
- MacLeod, A. K., & Conway, C. (2007). Well-being and positive future thinking for the self versus others. *Cognition and Emotion*, 21(5), 1114-1124.
- Mbokota, M., & Moodley, J. (2003). Domestic abuse - an antenatal survey at King Edward VIII Hospital, Durban : original article. 93(6), p.455-457. Retrieved from http://reference.sabinet.co.za/webx/access/electronic_journals/m_sami/m_sami_v93_n6_a25.pdf
- McCullough, M. E., Emmons, R. A., & Tsang, J.-A. (2002). The grateful disposition: a conceptual and empirical topography. *Journal of personality and social psychology*, 82(1), 112.
- McEntee, M. L., Dy-Liacco, G. S., & Haskins, D. G. (2013). Human Flourishing: A Natural Home for Spirituality. *Journal of Spirituality in Mental Health*, 15(3), 141-159.
- Moritz, S., Kelly, M. T., Xu, T. J., Toews, J., & Rickhi, B. (2011). A spirituality teaching program for depression: Qualitative findings on cognitive and emotional change. *Complementary Therapies in Medicine*, 19(4), 201-207. doi: <http://dx.doi.org/10.1016/j.ctim.2011.05.006>
- Mthembu, T. G., Ahmed, F., Nkuna, T., & Yaca, K. (2014). Occupational Therapy Students' Perceptions of Spirituality in Training. *Journal of Religion and Health*, 1-20.
- Mthembu, T. G., Roman, N. V., & Wegner, L. (2015). A Cross-Sectional Descriptive Study of Occupational Therapy Students' Perceptions and Attitudes Towards Spirituality and Spiritual Care in Occupational Therapy Education. *Journal of Religion and Health*, 1-17.
- Murray-Swank, N. A., & Pargament, K. I. (2005). God, where are you?: Evaluating a spiritually-integrated intervention for sexual abuse. *Mental Health, Religion & Culture*, 8(3), 191-203.
- Nordien, R., Alpaslan, N., & Pretorius, B. (2003). Muslim women's experiences of domestic violence in the Nelson Mandela Metropole : a qualitative study : research. 8(4), p.38-55. Retrieved from http://reference.sabinet.co.za/webx/access/electronic_journals/health/health_v8_n4_a5.pdf

- Olpin, M., & Hesson, M. (2015). *Stress management for life: A research-based experiential approach*: Cengage Learning.
- Oosthuizen, C. M., & Wissing, M. P. (2005). Prevalence of violence against women : distress, coping and psychological well-being. *Surviving the fire?* 35(4), p.637-656. Retrieved from http://reference.sabinet.co.za/webx/access/electronic_journals/sapsyc/sapsyc_v35_n4_a3.pdf
- Park, C. L. (2005). Religion as a Meaning-Making Framework in Coping with Life Stress. *Journal of Social Issues*, 61(4), 707-729. doi: 10.1111/j.1540-4560.2005.00428.x
- Pickthall, M. M. (1973). *The meaning of the glorious Quran*: Islamic Call Society.
- Piedmont, R. L. (2004). Spiritual Transcendence as a predictor of psychosocial outcome from an outpatient substance abuse program. *Psychology of Addictive Behaviours*, 18(3), 213-222.
- Polatajko, H., Townsend, E., & Craik, J. (2007). Canadian model of occupational performance and engagement (CMOP-E). *Enabling occupation II: Advancing an occupational therapy vision of health, well-being & justice through occupation*, 23.
- Post, S. G., & Puchalski, C. M. (2000). Physicians and patient spirituality: Professional boundaries, competency, and ethics. [Article]. *Annals of Internal Medicine*, 132(7), 578-583.
- Pretorius, G., & Pfeifer, N. (2010). Group art therapy with sexually abused girls. 40(1), 63-73. Retrieved from http://reference.sabinet.co.za/webx/access/electronic_journals/sapsyc/sapsyc_v40_n1_a7.pdf
- Saldana, J. (2009). An introduction to codes and coding. *The coding manual for qualitative researchers*, 1-31.
- Schulz, E. K. (2005). The meaning of spirituality for individuals with disabilities. [Article]. *Disability & Rehabilitation*, 27(21), 1283-1295. doi: 10.1080/09638280500076319
- Sells, J. N., & Hargrave, T. D. (1998). Forgiveness: A review of the theoretical and empirical literature. *Journal of Family Therapy*, 20(1), 21-36.
- Shaw, A., Joseph, S., & Linley, P. A. (2005). Religion, spirituality, and posttraumatic growth: A systematic review. *Mental Health, Religion & Culture*, 8(1), 1-11.
- Shealy, S. E. (2009). Toward an Integrally Informed Approach to Alcohol and Drug Treatment: Bridging the Science-Spirit Gap. *Journal of Integral Theory and Practise*, 4(3), 109-126.
- Sherry, K. (2010). Culture and cultural competence for occupational therapists in Africa. In R. Crouch & V. Alers (Eds.), *Occupational Therapy An African Perspective* (pp. 60-77).
- Simó-Algado, S., Mehta, N., Kronenberg, F., Cockburn, L., & Kirsh, B. (2002). Occupational therapy intervention with children survivors of war. *Canadian Journal of Occupational Therapy*, 69(4), 205-217.
- Singh, S. B. (2013). "Ahimsa" and Domestic Violence in the Metropolitan Area of Durban, South Africa.
- Teo, S. S. S. (2009). An Occupational Therapist's Contribution to Spiritual Care within a Palliative Care Setting: a student OT's perspective. *Australian Journal of Pastoral Care and Health*, 3(1).
- Udell, L., & Chandler, C. (2000). The Role of the Occupational Therapist in addressing the Spiritual Needs of Clients. *The British Journal of Occupational Therapy*, 63(10), 489-494.
- Unruh, A., Versnel, J., & Kerr, N. (2002). Spirituality unplugged: A review of commonalities and contentions, and a resolution. *The Canadian Journal of Occupational Therapy*, 69, 5 - 19.
- van der Kolk, B. A. (1994). The Body Keeps The Score: Memory & the Evolving Psychobiology of Post Traumatic Stress. Retrieved from www.trauma-pages.com/vanderk4.htm website:
- Webb, J., Toussaint, L., & Conway-Williams, E. (2012). Forgiveness and Health: Psycho-spiritual Integration and the Promotion of Better Healthcare. *Journal of Health Care Chaplaincy*(18), 57 - 73.
- Wegner, L., Caldwell, L. L., & Smith, E. A. (2014). A public health perspective of occupational therapy : promoting adolescent health in school settings : rehabilitation. 20(2.1), 480-491.

Retrieved from
http://reference.sabinet.co.za/webx/access/electronic_journals/ajpherd/ajpherd_v20_n2_1_a16.pdf

- WHO. (2003). WHO definition of health, from www.who.int/about/definition/en/print.html
- Wilding, C. (2002). Viewpoint. Where angels fear to tread: is spirituality relevant to occupational therapy practice? *Australian Occupational Therapy Journal*, 49(1), 44-47.
- Wong, S. R., & Fisher, G. (2015). Comparing and Using Occupation-Focused Models. *Occupational therapy in health care*.
- Worthington, E. L., Jr., & Sandage, S. J. (2001). Religion and spirituality. *Psychotherapy: Theory, Research, Practice, Training*, 38(4), 473-478. doi: 10.1037/0033-3204.38.4.473
- Yalom, I. (2005). with Leszcz, M.(2005) *The Theory and Practice of Group Psychotherapy*: New York: Basic Books.

APPENDIX 1.

- a. Ethical Clearance Certificate**
- b. Letter Of Amendment Of Title**



21 February 2014

Ms Nazeemah Soomar 9401439
School of Health Sciences
Westville Campus

Protocol Reference Number: HSS/1284/012

Project Title: Exploring the perceptions of Muslim women at a Shelter for Abused and Vulnerable Women regarding the role of spirituality in the therapeutic process

Dear Ms Soomar,

Retrospective – Expedited Approval

With regards to your response to our letter dated 09 September 2013. The documents submitted have been accepted by the Humanities & Social Sciences Research Ethics Committee and **FULL APPROVAL** for the protocol has been granted.

Any further violation of the UKZN Code of Ethical Conduct will result in a disciplinary process.

Any alteration/s to the approved research protocol i.e. Questionnaire/Interview Schedule, Informed Consent Form, Title of the Project, Location of the Study, Research Approach and Methods must be reviewed and approved through the amendment/modification prior to its implementation. In case you have further queries, please quote the above reference number.

Please note: Research data should be securely stored in the discipline/department for a period of 5 years.

The ethical clearance certificate is only valid for a period of 3 years from the date of issue. Thereafter Recertification must be applied for on an annual basis.

I take this opportunity of wishing you everything of the best with your study.

Yours faithfully

.....
Dr Shenuka Singh (Chair)

/ms

cc Supervisor: Professor Rosemary Crouch
cc Academic Leader Research: Professor JH van Heerden
cc School Administrator: Ms Phindile Nene

Humanities & Social Sciences Research Ethics Committee

Dr Shenuka Singh (Chair)

Westville Campus, Govan Mbeki Building

Postal Address: Private Bag X54001, Durban 4000

Telephone: +27 (0) 31 260 3587/8350/4557 Facsimile: +27 (0) 31 260 4609 Email: ximbap@ukzn.ac.za | snvmanm@ukzn.ac.za | mohunp@ukzn.ac.za

Website: www.ukzn.ac.za





UNIVERSITY OF
KWAZULU-NATAL
INYUVESI
YAKWAZULU-NATALI

15 May 2015

Ms Nazeemah Soomar 9401439
School of HEALTH Sciences
Westville Campus

Dear Ms Soomar

Protocol reference number: HSS/1284/012M

New Project title: Addressing Spirituality in Group Therapy: A Qualitative Study at a Shelter For Abused And Vulnerable Muslim Women in Durban

Approval Notification – Amendment

This letter serves to notify you that your request for an amendment received on 4 May 2015 has now been approved as follows:

- **Change in Title**

Any alterations to the approved research protocol i.e. Questionnaire/Interview Schedule, Informed Consent Form; Title of the Project, Location of the Study must be reviewed and approved through an amendment /modification prior to its implementation. In case you have further queries, please quote the above reference number.

PLEASE NOTE: Research data should be securely stored in the discipline/department for a period of 5 years.

The ethical clearance certificate is only valid for period of 3 years from the date of issue. Thereafter Recertification must be applied for on an annual basis.

Best wishes for the successful completion of your research protocol.

Yours faithfully

.....
Dr Shenuka Singh (Chair)
Humanities & Social Sciences Research Ethics Committee

/pm

Cc Supervisor: Professor Rosemary Crouch
Cc Academic Leader Research: Professor JH van Heerden
Cc School Administrator: Ms P Nene

Humanities & Social Sciences Research Ethics Committee

Dr Shenuka Singh (Chair)

Westville Campus, Govan Mbeki Building

Postal Address: Private Bag X54001, Durban 4000

Telephone: +27 (0) 31 280 3587/8350/4557 Facsimile: +27 (0) 31 260 4609 Email: ximbap@ukzn.ac.za / snymanm@ukzn.ac.za / mohunp@ukzn.ac.za

Website: www.ukzn.ac.za

1910 - 2010
100 YEARS OF ACADEMIC EXCELLENCE

APPENDIX 2:

**Letter Requesting Permission To Conduct Study At The
Women's Centre**

NAZEEMAH SOOMAR OCCUPATIONAL THERAPIST

B. OT (UKZN) PR NO: 6617506

33A MCCORD ROAD, OVERPORT, DURBAN ✦ 0827786 104 ✦ nazeemahs@gmail.com

23 June 2012

ATT: THE HEAD SOCIAL WORKER

WOMEN'S CENTRE

RE: RESEARCH TO BE CONDUCTED AT YOUR CENTRE

AS SALAAMU ALAIKUM

HOPE THIS LETTER RECEIVES U IN GOOD STEAD, INSHA ALLAH.

AS DISCUSSED PREVIOUSLY, AS PART OF MY MASTERS IN PHILOSOPHY DEGREE SPECIALISING IN GROUPWORK THERAPY, I WILL BE CONDUCTING RESEARCH TITLED: EXPLORING THE PERCEPTIONS OF ABUSED AND VULNERABLE MUSLIM WOMEN ON ADDRESSING SPIRITUALITY IN A GROUP. THIS WILL ENTAIL INTERVIEWING GROUP MEMBERS AFTER THEY HAVE ATTENDED A SERIES OF GROUP SESSIONS CONDUCTED BY MYSELF.

THE INTERVIEWS WILL LAST APPROXIMATELY AN HOUR, AND PATIENTS WILL BE INFORMED OF THE CONFIDENTIALITY, ANONYMITY, AND RIGHT TO WITHDRAW FROM THE STUDY, AFTER WHICH SIGNED CONSENT WILL BE OBTAINED.

ALL INFORMATION RECORDED AND TRANSCRIBED WILL BE HELD IN CONFIDENCE BY THE RESEARCHER, AS SHE HAS SIGNED CONFIDENTIALITY WITH YOUR CENTRE ON INITIAL CONTACT.

THE CENTRE WILL BE GIVEN FEEDBACK AND RECOMMENDATIONS BASED ON THE FINDINGS AFTER ANALYSIS OF THE DATA.

KINDLY RESPOND INDICATING YOUR APPROVAL OF THIS PROCESS.

MANY THANKS

MS N SOOMAR

OCCUPATIONAL THERAPIST

APPENDIX 3:

Gate-Keepers Permission



23 JUNE 2012

ATT: MS N SOOMAR

OCCUPATIONAL THERAPIST

RE: PERMISSION TO CONDUCT RESEARCH

DEAR MS N SOOMAR

YOUR LETTER REQUESTING PERMISSION TO CONDUCT RESEARCH TITLED:
"EXPLORING PERCEPTIONS OF ABUSED AND VULNERABLE MUSLIM WOMEN
ON ADDRESSING SPIRITUALITY IN A GROUP" REFERS.

THE CENTRE IS HAPPY TO GRANT YOU PERMISSION TO CONDUCT THIS
RESEARCH AT CENTRE.

WE LOOK FORWARD TO YOUR CORRESPONDENCE IN FUTURE.

M. Hassan

SOCIAL WORKER

APPENDIX 4:

Invitation To Participate In The Research

UNIVERSITY OF KWAZULU-NATAL
Department of Occupational therapy

MPhil Group Therapy Research Project
Researcher: Nazeemah Soomar (Tel: 0827786104)
Supervisor: Rosemary Crouch (Tel: 011 728 2852)
Research Office: Ms P Ximba 031-2603587

Dear Respondant

I, Nazeemah Soomar am a Masters of Philosophy (Group Therapy) student in the School of Health Sciences, at the University of KwaZulu-Natal. You are invited to participate in a research project entitled : Exploring the perceptions of Muslim women at a Shelter for Abused and Vulnerable Women regarding the role of spirituality in the therapeutic process.

The aim of this study is to: To explore the perceptions of Muslim women at a shelter for Abused and Vulnerable Women regarding the role of spirituality within the Occupational Therapy group program.

Through interviewing you I hope to understand if patients find dealing with spirituality in an Occupational therapy group a positive experience. Interviews will be voice recorded, stored under password control for analysis by the researcher and supervisor only. The findings of this research are intended to contribute to the knowledge of addressing spirituality within a group setting.

Your participation in this project is voluntary. You may refuse to participate or withdraw from the project at any time with no negative consequence. There will be no monetary gain from participating in this research project. Confidentiality and anonymity of records identifying you as a participant will be maintained by the researcher alone.

If you have any questions or concerns about participating in this study, please contact me or my supervisor at the numbers listed above.

It should take us about an hour to complete this interview. I hope you are agreeable to participate in the interview and research.

Sincerely

Researcher's
Date _____

signature _____

This page is to be retained by participant

APPENDIX 5:

Informed Consent Form

UNIVERSITY OF KWAZULU-NATAL
Department of Occupational Therapy

MPhil Group Therapy Research Project
Researcher: Nazeemah Soomar (Tel: 0827786104)
Supervisor: Rosemary Crouch (TEL: 011 728 2852)
Research Office: Ms P Ximba 031-2603587

CONSENT

I _____ (full names of participant) hereby confirm that I understand the contents of this document and the nature of the research project, and I consent to participating in the research project. I understand that I am at liberty to withdraw from the project at any time, should I so desire.

Signature of Participant

Date

This page is to be retained by researcher

APPENDIX 6:

Interview Schedule

Interview Schedule

1. Interview number: _____
2. Age: _____
3. Gender: _____
4. Religious affiliation: _____
5. Tell me a little about why you are here?

6. Have you attended group therapy previously?

7. How did you feel about the group therapy program that was presented at this centre
Probe:
 - Spirituality
 - Time, venue, length
 - Therapist facilitation
 - Skills transfer
 - Anything not useful

8. What do you understand by the term spirituality?
Probe:
 - religion vs spirituality
 - coping
 - family background

9. Do you think that group therapy was a good place to talk about spirituality?
Probe:
 - Intimidated
 - Vulnerable
 - Comfortable
 - relationship with therapist
 - commonality

10. Would you prefer talking to a moulana or aalima?

- 11.. How did you experience the spirituality presented in our sessions?:
Probe:
 - Coping
 - coming to terms with trauma
 - forgiveness
 - positive thinking
 - gratitude
 - stress management
 - are skills/experiences transferable to lifestyle

12. Do you think the groups impacted on your connection to higher power /meaning /
purpose