



**“INDIGENOUS FRUITS FROM EXOTIC ROOTS?
REVISITING THE SOUTH AFRICAN OCCUPATIONAL
THERAPY CURRICULUM”**



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DEDICATION

To my Almighty God, who has been a constant source of encouragement, inspiration and support throughout this thesis. Thank You for the privilege of being able to take this journey, for awakening me in the before-birdsong hours of the morning to whisper little challenges and suggestions in my ear, and most importantly, thank You for helping me to see the humour and irony in the fact that You created the brains that created the all-manner-of-belief systems of post modernism.



Sunrise over the Serengeti – August 2005

Photograph: Robin. Joubert

“In the beginning was the Word and the Word was with God, and the Word was God. He was with God in the beginning. Through him all things were made; without him nothing was made that has been made. In him was life, and that life was the light of men. The light shines in the darkness, but the darkness has not understood it.” **John 1-5** (The Holy Bible NIV 1978:113)

DISCLAIMER

I hereby acknowledge that this thesis is my original work and has not been submitted before to any other institution for assessment purposes.

In addition I have acknowledged all sources used and cited in the bibliography.

Researcher:


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Date


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Promoter:

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Date:

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ABSTRACT

This thesis explores the origins of occupational therapy in South Africa and how its birth, at the end of the Second World War, in a post-colonial era, with an emerging *apartheid* government, gave rise to an epistemology that was flawed from the start. It was flawed by virtue of its origins within a Eurocentric, paternalistic and male dominated health milieu which itself was strongly under the influence of the reductionistic and prescriptive medical model. It was flawed by virtue of the unnatural and oppressive nature of the country's governance at the time in which everything, including health care, was designed primarily to benefit those of European descent and disadvantage those of any form of brown skin descent. It was flawed in that it did not collaborate in the design of curricula and research with the very people it served, namely, people with disabilities and black South Africans.

Using historical and other relevant documentation, own life experiences, focus groups and the narratives of people with disabilities as data, this thesis attempts to expose the flawed layers described above and exactly how this impacted upon the epistemology of occupational therapy in South Africa. It also explores the changing face of occupational therapy globally and locally as a changing interface between what was then, what is becoming and what has to become in the future.

The thesis ends with a flexible model that has multi-dimensional properties that provide multi-dimensional possibilities both in portraying the historical influences upon professional development and in plotting identity and curricula changes. It suggests some inherent principles essential for restructuring the occupational therapy identity and curriculum to meet this identity. It draws sustenance from the resilience that the developing South African occupational therapy profession has displayed, despite all these odds, and attempts to reconcile the errors of the past with the fast-changing face of modern day occupational therapy as it relates to professional practice, theory, contexts, policy and research in South Africa today.

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KEY TO ABBREVIATIONS

ANC:	African National Congress
DPSA:	Disabled People South Africa
HPCSA:	Health Professions Council of South Africa
INDS:	Integrated National Disability Strategy
MEDUNSA:	Medical University of South Africa.
MOHO:	Model of Human Occupation
NQF:	National Qualifications Framework
OSDP:	Office of the Status of Disabled People
OT:	Occupational Therapist
OTASA:	Occupational Therapy Association of South Africa
RSA:	Republic of South Africa.
SAAOT:	South African Association of Occupational Therapists
SAMDC:	South African Medical and Dental Council
SAQA:	South African Qualifications Authority
SETA:	Services Sector Education and Training Authority
SGBS:	Standards Generating Bodies
UDW:	University of Durban-Westville
UKZN:	University of KwaZulu-Natal
UPAIS:	Union of Physically Impaired Against Segregation
WFOT:	World Federation of Occupational Therapy

KEY TO FONTS USED IN THIS TEXT

- | |
|---|
| - <u>Arial</u> will be used to represent general theory and background |
| - <i>Monotype Corsiva</i> will be used to represent postcards, letters and vignettes and expressing mostly Robin's subjective voice |
| - <i>Bradley Hand ITC</i> will be used to represent the voices of participants within the examples used from data analysed in, for example, focus groups and personal stories |
| - <u>Times New Roman</u> will be used to express the voice of the Researcher when commenting on data extracts. |

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Foreword

This thesis is a theoretical study exploring a range of conceptual arguments around the development of occupational therapy in South Africa and the effect of this particular history on its epistemology. The period of particular interest here ranges from the early 1940's to approximately 2005.

Setting the tone

Embarkation upon this thesis has, without doubt, been the most important academic journey of my life. It has been cathartic in that it has necessitated deep and sometimes painful interrogation of my ancestral roots and how these and other influences have impacted upon my own personal life-development and the development within my vocation and career as a white female occupational therapist in South Africa during the apartheid¹ and post-apartheid years. It has caused me to question those tracts of development that both I, and respected, committed colleagues, have plotted out and followed, without ulterior motive and with good intention, over the past 50-odd years of our profession's history in this country. It has become a journey, or perhaps more of an expedition (and latterly a pilgrimage), in which a process of exploring the roots, rivers, valleys and mountains of our backgrounds, thoughts and knowledge systems has occurred.

More of this will be revealed later, but for now it is important for you, the reader, to accept that there is absolutely no manner in which I can extricate myself from this journey if I am to be accountable for its revelations and ultimate thesis. It provides an opportunity in the autumn of my life, when I am about to cease my work as occupational therapist and teacher and relinquish these roles forever, to leave behind something of my seed to hopefully become zygotic with other theses and develop into a new and specifically more Africanised occupational therapy.

¹ Apartheid is the Afrikaans word for 'separateness' which was the term used by the Nationalist Government of the day to encapsulate a rigidly imposed and regulated policy of separate development of the various South African races from 1948 until its demise in 1994.

When and where appropriate during the progress of this thesis, I will be making use of an autoethnographical technique² in which I provide either extended commentary about my relevant past and personal experiences or brief inserts within the existing text. These include particular aspects of my own experiences as an occupational therapist in South Africa that I think may have a significant bearing upon parts of this thesis. These commentaries, i.e. a form of reflexive ethnography³, will be represented either as vignette or narrative box using the *Monotype Corsiva* font, or will be in the form of open comment and bracketed comment within the existing text, using the **Times New Roman** Font. These narratives and vignettes should not become the focus of the study but simply provide relevant background and /or illumination that will allow for greater transparency and/or lucidity in understanding the context.

The metaphor of a journey in search of roots and fruits is used throughout the various parts of this thesis. Throughout the journey, discourse will be revealed and expressed, not through some objectified “researcher” discussing deep and emotive issues close to her heart, in sterile and barren language that disjoins itself from the very chasms that need to be explored. Rather, every attempt will be made to retain rationality and sensibility throughout the expedition, with essential occasions when the pure visceral, instinctual and experiential ‘me’ may be released. I will also try to retain what Snipe and Spencer (2003)⁴ refer to as “empathic neutrality” in which the inability to be totally value-free is acknowledged, provided one makes one’s assumptions transparent.

² **Autoethnography** is an autobiographical genre of writing and research that displays multiple layers of consciousness, connecting the personal to the cultural. Auto ethnographers gaze back and forth through a wide-angle lens, outward on social and cultural aspects and their personal experience and then they look inwards, exposing a vulnerable self that is moved by and may move through, refract and resist cultural interpretations. [Ellis, C. & Bochner, P. Autoethnography, Personal Narrative and Reflexivity. In: Denzin, N. & Lincoln, Y. (2003)]

³ Ibid: i.e. reflexive ethnography in which the researcher’s personal experience is, or becomes, important mainly because of how it illuminates the culture under study.

⁴ Snipe, D. & Spencer, L. The foundations of qualitative research. In Ritchie, J. & Lewis, J. (Editors). (2003).

Out of keeping with normal research conventions which militate against writing that is personal and passionate⁵ I am determined that this thesis should be accessible not only to my occupational therapy colleagues but to individuals and organisations who advocate for change in the way in which we impart and share knowledge about the process of enabling health care workers to be more humble, sensitive and effective in their work. Ellis and Bochner (2003:200) express my approach perfectly when they describe chapters written in the third-person as if they are “*written from nowhere to nobody*”. Aggar⁶ echoes this, maintaining that, as academics writing for academics (amongst others), we should be trying to change the norm of restricted academic codes that are responsible for reproducing the hierarchy of writer over reader through academic obscurantism in order to make one’s work more accessible.

I have thus tried to keep the language more easily readable, avoiding wherever possible the sometimes pompous and ostentatious jargon and clichés, or horribly complex Foucauldian sentences that some academics and researchers are prone to use. I will also attempt to treat the writing of this thesis as a dynamic and creative process in which language is a constitutive force that creates a particular view of reality and of the self (Richardson, 2003)⁷. Richardson also suggests that the purpose of qualitative research is in the reading and as such the written word should be read with interest and intent and not scanned.

Having played a significant part in occupational therapy education in South Africa, both as educator (lecturer) and as member of National Professional Education planning and policy-making bodies since 1976, and having personally known some of the early pioneers in occupational therapy, I have considered my own experiences as being an integral and important part of the data used to

⁵ Ellis, C. & Bochner, P. Autoethnography, personal narrative and reflexivity. In: Denzin, N. & Lincoln, Y. (Editors). (2003).

⁶ Agger, B. Introduction: Critical Theory Goes Public. In: Agger, B. (1991).

⁷ Richardson, L. Writing: A method of enquiry. In Denzin, N. & Lincoln, Y. (Editors). (2003).

substantiate this thesis. It is thus important that I position myself at the outset in terms of my own status as a white South African in a country with a history such as ours.

In doing this I have had to reveal some personal and intimate histories, perceptions and recollections of people who were either very special to me or who form part of my genetic heritage and as such I have tried to respect the loyalty that such a position demands of me without losing the essence of my interpretation of the truth within this past. Most of these people are no longer here to defend themselves against what I say and thus it should be respected throughout that it is purely my own personal interpretation of my roots, an interpretation with which some of those I speak about may not have completely concurred.

This thesis is structured in three parts: **PART 1** provides an orientation to the rationale and theoretical framework as well as the methodology. Next, it takes the reader on a genealogical journey through the author's ancestry and origins; then reviews the history of the development of occupational therapy in South Africa and globally and demonstrates how paternalistic, medical model influences have infringed upon the integrity and identity of the profession in this country. It goes on to explore the impact of apartheid upon health care in general and upon rehabilitation specifically. It concludes in a synopsis of the core tenets defining occupational therapy and its basic epistemology, and summarises how these historical influences have impacted upon this epistemology.

PART 2 continues the theme in part 1, but now begins to explore the impact that the historical influences already identified have had upon the relationship between the occupational therapist and those we are trained to serve, namely, people with disabilities and black South Africans. It then tries to isolate the core impacts that the racist, discriminatory and segregationist apartheid had upon the epistemology of occupational therapy in South Africa.

PART 3 commences with the life-story narrative of a disabled youth to illustrate flaws in the epistemology revealed in parts 1 and 2, and to extract the core principles essential to reconstruction and re-establishment of a more appropriate epistemology. In concluding it touches on the changes that have occurred within the profession over the past 20 years and suggests a theory for dealing with these changes.

This thesis will reveal that occupational therapy in South Africa is a marginalized profession that has, for too long, not been taken seriously as an integral and essential component of the many forms of health intervention which not only provide cure for illness but sustenance for ongoing wellness. It also touches on occupational therapy's evolving agential and advocacy role, one of *enabling occupation* for individuals or groups who may not be ill or disabled but who need to overcome, for example, socio-political circumstances of occupational injustice or deprivation⁸.

It will reveal the historical origins of occupational therapy in this country and how these origins have impacted upon the distortion of our knowledge base as well as how they have suppressed the inclusion of essential knowledge, including indigenous knowledge, into our epistemology. It will mine the broadening chasm between what was expected of South African occupational therapists in the infancy of the profession and what is expected of them today, and how this has alienated us from those we are supposed to serve. It will also briefly review some of the existing theoretical models and frameworks underpinning our particular global worldview and consider whether these are adequately articulated and appropriate to our unique context. Finally, it will suggest broad changes necessary to the South African occupational therapy identity to make it more appropriate to the needs of the people we serve.

⁸ These terms will be discussed in more detail in chapters 5 and 11 of this thesis.

PART 1

Historical Journey: Searching the Roots to throw light on the Routes

- 🌐 **Mapping the route: the rationale for this thesis and the theoretical framework guiding it.**
- 🌐 **Method of travel and instruments of navigation: a description of the methodology.**
- 🌐 **(Un)packing the baggage and setting the compass straight: the researcher's origins as a point of departure.**
- 🌐 **(Un)packing continues: a historical review of the development of occupational therapy in South Africa and a summary of the history of the development of occupational therapy globally.**



Photo: Deonette van Zyl

My Jack Russell terriers and I on a remote beach of the “Wild Coast”, Transkei, Eastern Cape. May 2005.

CHAPTER ONE

Mapping the Route

Route map: This chapter sets out the route of the journey that this thesis will take by providing a brief collage of the researcher's early experiences as a lecturer at the University of Durban-Westville and as occupational therapist working for the Natal Provincial Health Services in the early 1980's. It explains how the course of the journey changed during the early process of data analysis, resulting in a detour away from the original route to explore and follow new and more relevant insights divulged by this early phase of data gathering and analysis. The evolution of the theoretical framework is outlined in this chapter. It provides a rationale of the progressive steps leading to the birth of the thesis and an outline of the key research questions. It motivates and justifies the theoretical framework that was used to influence and guide the researcher's point of view and provide the lens through which data will be analysed.

Postcard #1 – A personal reflection.

More than half of my life up to the present has been dedicated to the practice, development and teaching of occupational therapy in South Africa and now that this term is coming to a close, I have been drawn more and more into reflection upon my life within this vocation. In the early days it was a constant driving force to keep abreast of the struggles that intertwined like a huge knot of writhing snakes, pulling and twining and intertwining and separating. One moment suffocating, and the next causing me to gasp in excited amazement. One moment the ratatatatat of gunshot, stifling smell of tear gas, bark of police dogs, scream of students, and shatter of breaking glass from rocks hurled in furious indignation, accompanied by the ratatatatat of my adrenalised heart, as I sit waiting for the 'enemy' to come and stone me in my fancy white-washed office with its white paged books and white shadows on the wall. The next moment lifting the lifeless brown limbs of the 'enemy' as he lies motionless on the sterile white sheets of a hospital bed, the life blown out of his spine by the bullet of an FN rifle: a head without a body, breathing and thinking but not moving. Manhood can you be raised again? The enemy becomes the patient, becomes the friend, becomes the conscience.

("Me" - 1980's)

Introduction

Occupational therapists are trained to understand and appreciate the holistic nature of humankind and the essential and enabling power of all forms of human occupation as being integral to the quality of existence. As such they are able to utilise these enabling powers of occupation to achieve greater independence and quality of life for those who are already physically or mentally ill or disabled, maintain wellness for those at risk of illness or disability and advocate for those who, even without illness or disability, are deprived of the right to adequate and/or equitable human occupations, because of the potentially negative impact of this upon their health.

This thesis is an exploration of the journey of myself as an occupational therapist and professional educator at university, within an evolving profession, in a country as it moved from its apartheid history to an emancipated legal democracy.

Orientation to the structure of this report

This chapter will describe how data production commenced from a phenomenological perspective in which the original focus of data production was to explore those phenomena influencing the practice of occupational therapy in South Africa, particularly as these related to its appropriateness to, and efficacy within, our particular time and context. Data analysis at this stage was thus thematic and concerned with grounded theory.

After the analysis of the first three data sets, it became increasingly apparent that these phenomena could not be understood divorced from the time and context within which they had developed. It thus became evident that the phenomenological lens was too narrow an analytical lens for this particular research and that it would be necessary not only to use more appropriate lenses, but to exclude some of the original sets of data and include other, more appropriate sets and sources of data that were congruent with the new theoretical lenses.

Because of the particular context into which occupational therapy was born, early data analysis revealed issues related to power, discourse and competing voices, which required a deepened level of analysis. The original phenomenological stance was thus

rejected in favour of theoretical lenses that were particularly focussed on issues of power, discourse, suppressed voices and historical context. It was thus that feminism, Foucault and, to some extent, also critical theory, were selected as they facilitated a much deeper and more revealing exploration of occupational therapy's epistemology in South Africa.

The rationale behind this thesis – changing lanes

An interesting but predictable evolution occurred during the first three years of preparation towards writing up this thesis. The original research proposal was concerned with what I believed to be a broadening chasm between what occupational therapy was when I qualified 33 years ago, what it has become today and what its future potential is, given the national and global dynamic nature of health care and humanity. Concomitant with this concern was the possible failure, particularly within the educational component and within the South African context, to keep abreast with ensuring that graduates who leave our courses are competent in dealing with this rapidly changing professional scenario.

I therefore reasoned that the best way to explore whether this concern was valid or not was to start at the end, which required a phenomenological study of the content of course outcomes and the methods of assessment currently being used by universities training occupational therapists in South Africa, to measure the final competencies of qualifying occupational therapists.

As with all research, progression on this journey necessitated intense submersion in a whole new world of philosophical and other relevant theoretical readings which kept yielding new and yet unexplored dimensions around the original topic of my thesis. In addition to this I also started analysing my first four sets of data.¹ The combination of

¹ See Chapter 2 pages 37-38. These sets of data included: **first set**: copies of the 8 submissions of University's training Occupational Therapists, of their exit level outcomes and associated assessment criteria for registration of their degrees with the South African Qualifications Authority (SAQA). The **second set** of data was the findings of the analysis of four focus groups held in three provinces to evaluate perceptions on changes in the profession, strengths/abilities unique to South African OT s and whether current methods of assessing final competencies were adequately doing so. The **third set** of data were the 13 e-mail feedbacks I received from my resonance groups containing their comments on the summary of the analysis of data sets 1 and 2 above. A **fourth** refers to the latest statistics of occupational therapists registered with the Health Professions Council of South Africa (24 October 2004).

these two activities, coupled with ongoing reflections, meetings and interactions with colleagues, resulted in a growing uneasiness and realisation that exploring occupational therapy through a new and different lens could convert what had originally been so 'familiar' into something which became 'unfamiliar' and as such create a new and provocative perspective into the South African occupational therapy epistemology. There were so many questions surrounding the powerful, oppressive and patriarchal influences impacting upon the epistemology and philosophy of our profession in South Africa, and indeed globally, that it suggested a revisiting and a rejuvenation of our curriculum to firmly establish a new and distinct identity. This would, in turn, necessitate the development of new competencies.

It thus became apparent that any attempt to try and establish whether the assessment methods used by South African Universities who were training occupational therapists, were appropriately assessing the necessary competences in our graduating therapists, would be futile if we had not yet at least consolidated consensus around what these competences were and agreed on the core principles and factors underpinning our unique identity, philosophical framework and worldview, particularly within an African context. It was at this stage that I decided to abort the original route I was taking and rather detour to explore historical factors which impacted upon the development of the South African occupational therapy epistemology and how these have influenced its broad curriculum today.

The key questions of this research are thus as follows:

1. What is the changing nature of the role and scope of practice of occupational therapy both nationally and globally?
 2. How has the history of development of the knowledge systems of occupational therapy within the South African context affected this changing role and scope?
 3. How can the epistemology of occupational therapy be adapted to reflect a more appropriate South African identity?
-

4. How can the broad South African Occupational Therapy curriculum be adjusted to produce graduates that reflect and practise this identity?

Motivating the theoretical framework and lenses for data production and analysis

During the progression of this thesis, analysis and engagement with the various data sets made me progressively aware of the inability of occupational therapy as a profession in South Africa to adequately articulate and position itself with regard to a unique identity, more particularly, one incorporating the essential South African ingredient for this identity. There is also a need to reach consensus upon the key and core philosophical constructs underpinning this identity. This lack applies not only to the content of South African OT curricula but also, in my view, to the paucity of evidence in the day-to-day discourse of South African therapists of a concerted effort to position ourselves within a suitably progressive and appropriate world view and philosophical framework which would both redress our history and be in harmony with our profession's inherent ethos. Such a framework should incorporate the dynamic and changing nature, times and context of occupational therapy in South Africa and the global world of today.

To date, attempts at articulating an identity and philosophical framework for occupational therapy in South Africa appear to have relied largely upon a hodgepodge of various models, predominantly stemming from Western and European origins with only vague and fleeting references to African knowledge systems and philosophies. As researchers' objects of enquiry are constructed out of the materials provided by their culture, values are also central in this linguistically, ideologically and historically embedded project we call science (Lather, 1992)². It is this Eurocentrically biased science, which forms the foundation upon which the South African occupational therapy curriculum is built.

Mocellin (1992)³ maintains that occupational therapy models have been developed exclusively in the Western world and Kortman (1994)⁴ questions how appropriate these models are to other cultures. Kortman further states that models are culturally bound and

² Lather, P. Post-modernism and the human sciences. In: Kvale, S. (Editor). (1992).

³ Mocellin, G. (1992). **An overview of occupational therapy in the context of the American influence on the profession.** British Journal of Occupational Therapy. Volume 55(1):7- 8.

⁴ Kortman, B. (1994). **The eye of the beholder.** Australian Journal of Occupational Therapy. Volume 41:115-122.

do not exist, nor are they derived in cultural isolation. Before professional models are adopted it is necessary to produce evidence of their wider application within many cultural frameworks. In addition, Hudson (2002)⁵ maintains that in seeking to address the differences between traditions in relation to teaching and learning, it is first essential to acknowledge that terms such as *curriculum* and *didactic* are strongly culture bound.

I am not suggesting that we should not be influenced and guided by the developments taking place in Western countries: the current rapidity of globalization brought about by the amazing progress in the field of information technology and air travel has brought the world to our doorstep within seconds or hours. We would therefore be both naïve and foolish not to train our occupational therapists to be able to work anywhere in the world. But most important is to ensure that they are first competent in dealing with the particular health needs of our country and continent and its diverse populations where the need is greatest.

As a profession, the South African occupational therapy profile is largely skewed towards white, middle-class Judeo-Christian women⁶ and, as such, it is likely that the employment of this group in key positions such as heads of occupational therapy training, heads of clinical departments and other organisations serving the disabled community, is high. Thus, because of the comparative scarcity of other race groups within the profession, and in spite of affirmative action, predominantly white, middle-class Judeo-Christian women still form an important group of role models and influencers in the development of knowledge systems and relevant policy in South African occupational therapy at this stage of our history.

Given the diversity of cultures and races in South Africa, the profile of the occupational therapy profession begs the question that Michael Iwama (2006:18)⁷ asks: “*how do the*

⁵ Hudson, B. (2002). **Holding complexity and searching for meaning: Teaching reflexive practice.** Journal of Curriculum Studies. Volume 34 (1):43-57.

⁶ Statistics taken from the latest HPCSA register (25 October 2004) show the following percentages of registered occupational therapists according to race group:

Asian 3.6%; African (other than SA) and Black (ethnic) 4.34%; White 37.6% and two categories referred to as European (from Europe) 0.19% and blanks (unknown origin) 57%.

It is likely that although this category, where race is not specified, but based on surname may contain some African, Indian and Coloured therapists e.g. Jack, Olifant and Hendricks, the majority of this category are still white. Thus the 37.6% given for whites above is very conservative and more likely to be above 50%. In addition the percentage ratio of women to men is 96% to 4%.

complex meanings and essential ties to human well-being ascribed to the concept of occupation by occupational therapists situated in the West fare when taken into other cultural contexts? Do they carry the same veracity and explanatory power when placed in alternate spheres of social experience?"

In addition, and largely because of historical influences which will be discussed in more detail in Chapter 4, occupational therapists still have a preoccupation with, and embeddedness within, the positivist, reductionist medical model of health care. This, coupled with a lack of concerted effort to adequately engage with the disability activist discourses occurring around other more appropriate models has, I believe, alienated us from the very people we should be serving i.e. people with disabilities. We should be empowering such individuals through facilitation, and assisting them to access the appropriate resources and knowledge necessary to overcome prevailing perceptions and indoctrinations that they are the passive objects of research and assistance from others (Finkelstein 1980)⁸.

A constant refrain within the discourses of disabled activists concerns their disenchantment with the medical model, health professionals in general and rehabilitation more specifically. Finkelstein maintains that for almost every aspect of life of a person who is disabled, there is a professional counterpart situated either within a profession or voluntary organisation. He maintains that, as a result of this, the potential and real control over the life of a disabled person is a fact. This hegemony by such professionals and organisations has resulted in their having an almost absolute monopoly over articulating, and defining to the public at large, the problems of disabled people. It is this helper/helped relationship that defines the paradoxes between rehabilitation professionals and people with disabilities and as Finkelstein (1980:11) puts it, *"far from being detached from the **live problems** of disabled people the creation of rehabilitation professionals has its origins in the genesis of disability. This sets the constraints for their approach to the complementary side of the disability paradox, the helped: 11"*⁹. This is a particularly significant statement because it clearly demarcates

⁷ Iwama, M. Situating occupational therapy's meaning. In Iwama, M. (2006) *The Kawa Model: Culturally relevant occupational therapy*.

⁸ Finkelstein, V. (1980). **Attitudes and Disabled People**. Monograph No 5. World Rehabilitation Fund International. New York.

⁹ Ibid

and positions us as being in an oppositional camp to that of people with disabilities. Chapter 7 will cover these issues in more detail.

The theoretical framework underpinning the interpretation of data and the discussion and arguments within this thesis

Since 1994 and the change to a democratically elected government in South Africa, the new government has developed and implemented a number of policies and pieces of legislation that impact both directly and indirectly upon delivery of health services. In her introduction to the synopsis of these health policies and legislation, the Minister of Health, Dr Manto Tshabalala-Msimang, states that, while we have been told that South Africa has some of the world's best policies, she acknowledges our struggle to implement them (Pillay and Marawa, 2000)¹⁰.

Amongst these strategies, policies and legislation, but not included in the particular synopsis mentioned above, is a progressive and welcome White Paper titled the Integrated National Disability Strategy (INDS)¹¹, which suggests a social model framework for disability issues in South Africa, the integration and coordination of disability issues in all Government development strategies, planning and programmes, as well as a similar management system for planning, implementing and monitoring these. Key policy areas are identified and the right of disabled people is declared as protected by the constitution. The emancipatory tone of this document is a very welcome challenge to South African occupational therapists and rehabilitation professionals in general.

¹⁰ Pillay, Y. & Marawa, N. (2000). **A Synopsis of Health Policies and Legislation: 1994- 2000**. Department of Health, Government of South Africa. Pretoria.

¹¹ An Integrated National Disability Strategy (November 1997), The White Paper of the Office of the Deputy President. Rustica Press, RSA.

Wilcock¹² characterised occupational therapy teaching in the late 1950's and early 1960's as didactic and authoritarian, a practice which she maintained did not prepare therapists to defend the value of occupation to health when faced with the increasingly reductionist, scientific and technical stance adopted by medicine. It is argued that if the field of occupational therapy is to evolve into legitimate professionalism then occupational therapists need to develop far greater comfort and capacity for critical analysis¹³.

This capacity for critical analysis is especially relevant to South African occupational therapists in order to *really* transform the profession, and meet the related health needs of our country. We also need to be able to critically analyse relevant policy and legislation and advocate for changes where necessary. In addition, we should be able to position ourselves within the broader debates and developments that are currently taking place around our profession globally and provide appropriate and valuable input which has been enriched by our unique position and experiences within the African context.

Yerxa (1995)¹⁴ suggests that a profession establishes and sustains its own practice, education and standards based upon a unique body of knowledge, and thereby establishes and maintains its own identity. It should meet a specific human need and possess substantial autonomy. For occupational therapists this autonomy is directly related to our ability to serve, and to empower those we serve.

¹² Wilcock, A. Introduction. In: Wilcock, A. (Editor) (1998).

¹³ Hooper, B. & Wood, W. (2002). **Pragmatism and structuralism in occupational therapy: The long conversation.** American Journal of Occupational Therapy. Volume 56(1):40-50.

¹⁴ Yerxa, E.J. (1995). **Who is the keeper of occupational therapy's practice and knowledge?** American Journal of Occupational Therapy. 49 (4): 295-299.

¹⁵ Christiansen C (1999) **Defining lives: Occupation as identity: An essay on competence, coherence and the creation of meaning.** American Journal of Occupational Therapy Volume 53(6): 547-558.

¹⁶ Chevalier, M. (1997). **Occupational therapy and the search for meaning.** British Journal of Occupational Therapy. Volume 60(12): 539-54.

Global debates within the profession frequently question and criticise our ability to accurately define our role and actualise our potential. Christiansen (1999)¹⁵ maintains that a full and genuine appreciation of the power and ability of occupation to promote health and well being has not yet made its way across the landscape of the profession. Chevalier (1997)¹⁶, after perusing many issues of relevant occupational therapy journal articles, states that his long-held impression that occupational therapy is a profession still defining itself, and still in search of meaning, was confirmed. Hence this evolving status of the profession situates South African occupational therapists in an ideal position to trademark its specific identity.

Our infamous history and the emerging democracy have necessitated conscientising of health professionals to the socio-political realities that impact upon the health of individuals, groups, communities and the country as a whole. This in turn has necessitated interpretations of practice that are alternative to those traditionally associated with the profession (Duncan, Buchanan and Lorenzo, 2004)¹⁷. The type of critical exploration that this thesis will undertake necessitates that the birth, growth and development of occupational therapy globally, but more specifically locally, should be explored from an historical perspective.

Studying the development of a profession from an historical perspective will suggest factors behind the evolution, survival or demise of past characteristics of the profession and hence, perhaps, of the future characteristics required of the profession¹⁸. Such factors alert the historicist within us to trends and cycles from the past that have influenced change and the fixation of trends and cycles that have possibly resulted in inertia. They also reveal how unique and often random occurrences can channel events¹⁹. It is for these reasons that I have commenced this thesis with a macro-historical exploration of the development of the profession of occupational therapy, particularly within South Africa.

¹⁷ Duncan, M. Buchanan, H. & Lorenzo, T. (2004). Politics in Occupational Therapy Education: A South African Perspective. In: Kronenberg, F. Algado, S. & Pollard, N. (Editors). (2005).

¹⁸ Cocks D. (1999) **The role of history in future gazing**. A talk to the Independent Scholars Association of Australia. <http://www.labshop.com.au/dougcocks/ISAAtalkhtn>.

¹⁹ Ibid.

In order to build a South Africa that is well developed and prosperous (and populated with healthy and happy people) we need to look into the future, not as clairvoyants with the power to foretell the future, but as practical, ordinary South Africans, conscious of the reality that a better future is possible for all our people. Thus, by planning properly today, adopting correct policies and consistently implementing these policies without fail, this will be possible²⁰.

It was against this historical background of occupational therapy's development in South Africa, in which so many voices were silenced or muted; so many people oppressed and undermined; so much knowledge not accessed because it had been deemed primitive and inferior, and because there had been such stringent enforcement of a particular '*truth*', that it was essential that I started out on the road using the theoretical lenses of feminism, Foucault and critical theory because they particularly lend themselves to an exploration of how the dynamics within this particular history could have impacted upon the development of occupational therapy's epistemology.

Emergent evidence of a dominant patriarchal force in the development of what was, in the early days, an exclusively female profession, required that the resultant gender tensions and suppressed voices be brought into focus under a feminist lens. Furthermore, this lens complemented Foucault's belief that truth and knowledge cannot be separated from the procedures of their production²¹. Foucault's theories on the relationship between knowledge and power and his often cryptic analysis of the strategies of power and its subversive outcomes on its victims also became relevant to this particular research. In addition, the lens of critical theory was used to reveal the injustices of this history, inflicted not only upon occupational therapy's development, but also upon the people that occupational therapists are trained to serve.

In this thesis Foucault's theories on power relations are particularly related to disciplines in the health fields, investigating how these power relations are often subtly elicited and deployed to regulate human behaviour and how, in the case of occupational therapy's

²⁰ Mbeki, T. Foreword. In: Bowes, B. Lundy, G. & Pennington, S. (Editors).(2004).

²¹Tamboukou, M. (2003) **Writing feminist genealogies**. Journal of Gender Studies. Volume 12(1).

development in South Africa, power relations resulted in the construction of a '*reality*' that was not ideally suited to the ethos of the profession.

Other aspects of Foucault's thinking that are relevant to this research include those on *surveillance* and *confinement*, particularly as they relate to people with disabilities, as well as his particular views on *genealogy and discourse* and how meanings work together historically to create a specific/desired type of reality and the ways in which discourse constructs subjects²². Foucault's theoretical conceptions will be discussed in chapters 8 and 10 of this thesis, which will examine how they were used in power and discourse analysis, as well as how they support the thesis's arguments.

As alluded to in the foreword, I have made use of a provocative, evocative and reflexive, autoethnographic writing practice, writing in the first person and using a variety of personal life fragments, some of which are highly personal, others simply relational and institutional stories affected by, and connected to the history of the profession of occupational therapy in South Africa. This form of reflexivity is used to demonstrate to my audience my historical, geographical and socio-political situatedness within the research²³. In keeping with the ethos of feminism, Foucault and critical theory, it would be unfair to search for the marginalised and oppressed voices of affected participants within this research without situating myself and adding my own voice as part of the multivocal evidence revealed in the data sets.

Discourse analysis and Foucault

The exploration of the underlying dynamics that gave rise to this thesis will necessitate a critical and systematic interrogation of the history and development of occupational therapy as a profession; how its marginalisation occurred and has been revealed through the profession's own discourse. This will follow both a global and local review of the profession's development, but the emphasis will particularly be upon the South African context. Hence, and in view of the interplay of multiple and complex historical forces during the period of this development, special attention will be given to an

²² Fendler, L. (2003). **Teacher reflection in a hall of mirrors: Historical influences and political reverberations.**

²³ Gergen, M. & Gergen, K. (2003) Qualitative inquiry – tensions and transformations. In Denzin, N. & Lincoln, Y. (2003). **Collecting and interpreting qualitative materials.** Sage.

analysis of the foundations upon which knowledge in occupational therapy was generated and how some of this knowledge has become subjugated.

According to Foucault, subjugated knowledge refers to two things: firstly, those blocks of historical knowledge that are present but disguised and which criticism has been able to reveal, and secondly, whole sets of knowledges that have been revealed through criticism²⁴.

Foucault²⁵ also refers to subjugated or disqualified knowledges that have been disqualified as inadequate or naïve, and located low on the hierarchy, beneath a required level of cognition and scientificity. This notion is relevant to the historical suppression of the indigenous knowledges of all South Africans other than whites, particularly as it applies to the field of occupational therapy.

Using Foucault's theory on genealogy, the historical discourse of occupational therapy in South Africa will be examined. Genealogy, through this lens, does not search for origins but assumes rather that concepts emerge in discourse as a result of multiple external and historical influences. It explores how meanings work together historically rather than how they fit together analytically. This thesis will thus concentrate on the historical and discursive complexities of the development of occupational therapy as a profession and expose the power relations that have impacted upon how occupational therapy is perceived as a profession in South Africa today²⁶.

Also related to this is Foucault's paradoxical view of, and fascination with, the fact that as humans within contemporary history we are both the subjects of history, as active agents within it and the objects of history, as topics of discourse²⁷.

As already mentioned, occupational therapy was born in South Africa in a period when the forces in control of it were extreme and unnatural by most standards. And even a

²⁴ McHoul, A. & Grace, W. Foucault's counter-history of ideas. In: McHoul, A. & Grace, W. (Editors). (2000).

²⁵ Ibid

²⁶ Fendler, L. (2003). **Teacher reflection in a hall of mirrors: Historical influences and political reverberations**. Educational Researcher. Volume 32(3): 16-25.

²⁷ Smart, B. Questions of method and analysis. In: Smart, B. Editor. (2004).

cursory enquiry into the genealogy of occupational therapy's precursors reveals that its roots took hold within conflict situations such as world wars and human crises²⁸.

A portion of the data informing this thesis has been documentation on the historical background of the profession, documents outlining outcomes of training and documents outlining control and legislation of therapists. Foucault (1969)²⁹ maintains that traditional history which undertook to "memorise" the *monuments* of the past and transform them into *documents*, lent speech to those traces which by their very nature are not verbal or convey something covert, thus transforming *documents* into *monuments*. As one of the consequences of this, the history of our time becomes archaeological in its intrinsic description of the monument. A final consequence of this is that the *new* history is confronted by a number of methodological problems, some of which may have existed before the emergence of the new history but when combined, characterise it. This thesis will explore how the history of the development of occupational therapy in South Africa reveals a document/monument interplay and what methodological problems characterise it.

Critical Theory

The ideological positions from which critical theory arises lend themselves comfortably to the nature of this particular exploration. Ontologically the study will be considering how the development of occupational therapy's reality has been shaped over time by a complex collection of social, political, cultural, economic, ethnic and gender factors, and how these have been reified into a series of 'truths' that are now taken as 'real', natural and immutable, and an historical reality³⁰.

Epistemologically, critical theory is transactional and subjectivist, and by using an autoethnographical stance to situate myself within the research I have tried to show how I as investigator, those under investigation, and our values, are interactively linked thus inevitably influencing the enquiry. The findings are thus *value mediated*³¹. Methodologically this particular enquiry has a generally transactional nature, and thus

²⁸ The historical background to the profession will be outlined in Chapter 4.

²⁹ Foucault, M. (2003). **The archaeology of knowledge**. Routledge Classics, London

³⁰ Denzin, N. & Lincoln, Y. Competing paradigms in qualitative research. In Denzin, N. & Lincoln, Y. (1994)(Editors).

³¹ Ibid

where appropriate, has required a dialogue between the investigator and subjects of enquiry. It attempts to transform ignorance and misapprehensions about occupational therapy's epistemology by revealing to the reader how historically mediated structures that were considered immutable can be transformed into structures that more closely reflect the reality of occupational therapy in South Africa today³².

The context within which occupational therapy was born in South Africa was so complex, with extreme levels of oppression, racial and gender discrimination and hegemony, that it is logical to assume that its epistemology must have been flawed.

Thomas Popekewitz (1990:50)³³ maintains that a *critical* science provides reference to a systematic enquiry that must focus upon "*the contradictions of educational practice*". He further maintains that "*social values, struggles, and interest influence the questions, concepts and strategies of educational science*".

Dubow (1995)³⁴ maintains that white historians need to interrogate their own collective pasts, not simply as a *mea culpa*, but in order to recognise themselves as historical agents and products. Not only are many of them guilty of writing off the past too glibly and casually, but they also fail to adequately see their role within that past and how it has moulded their knowledge base and attitude. They have to acknowledge their place as racists, albeit passive racists, within a racially segregated country. Dubow (1995:5)³⁵ also maintains that racism has been an undeniable and inseparable part of the structure of South African society and that patterns of prejudice and paternalism have been "*deeply imbedded in the collective mentalities of white South Africans, for whom notions of superiority, exclusivity and hierarchy exist as more or less conscious 'habits of mind'. Together they comprise a folkloric amalgam of popular beliefs and traditions in which the idea of human difference has been accepted as natural and incontestable*".

While white South Africans were the perpetrators, I would contend that the apartheid system was a perfect culture for evoking racism amongst all racial groups in this country. As surely as the white race discriminated against "non-white" races, so too must the

³² Ibid

³³ Popekewitz, T. Whose future? Whose past? Notes on critical theory and methodology. In: Guba, E. (editor). (1990).

³⁴ Dubow, Saul. (1995). **Scientific racism in modern South Africa**

³⁵ Ibid

“non-white” race groups have despised them for this discrimination. As such, tensions between races were set in place that must have influenced the nature of the occupational therapy of those under the therapists’ care as well as their response to occupational therapists treatment of them.

I believe that, as white South African occupational therapists, some could well have been guilty of underplaying the political importance of the times in which they were developing our profession, and of being so blinkered by the need to gain the recognition of the academic institutions in which they were developing the occupational therapy curricula, that they did not adequately see beyond the typical questions, into those critical questions, that would have positively influenced the epistemology of South African occupational therapy.

It has been pointed out that there is inherent racial bias in educational research that unquestioningly accepts a white European-American (or western for that matter) epistemological framework over more race-based paradigms³⁶.

This form of critical theory tries to expose the political discourse and colour blind initiatives that act as pretexts for racial discrimination and will be used to expose the flaws in the colour blind position by attempting to reveal how black African, Indian and Coloured students have to compromise their race and culture to fit into the white, Eurocentrically oriented curriculum experience.

Parker³⁷ maintains that critical race theory is a race-based epistemology that also relies to a degree on interpretive frameworks such as feminism, critical theory and post-modernism. As such it seeks to speak to and analyse the ways in which race and racial discrimination fundamentally operate through the law as well as how race may intersect with gender, class, language, culture and other areas of difference.

³⁶ Ibid

³⁷ Ibid

Epistemological racism is an unconscious form that stems from the historical domination of society and its philosophers by white cultures that created the basis for how knowledge is pursued³⁸.

The analysis of certain sets of the data revealed the power differentials and ideological ladenness of the occupational therapy context. This does not, however, mean that the goal of the study was to eliminate inequities and bring about greater social justice, even though a potential (yet untested) consequence might be to shift thinking about occupational therapy in terms that are not neutral.

Feminism

This thesis will also explore the influence of various hegemonies and oppressive instruments which impacted upon the epistemology of South African occupational therapy, and which distorted the true nature of the identity and knowledge systems upon which they impinged (Butchart, 1997)³⁹. These knowledge systems have been influenced by factors such as the overriding historical and current profile of occupational therapy as a predominantly white, middle-class, Judeo-Christian, female-oriented profession which was initially influenced and controlled almost exclusively by patriarchal, white, male, Judeo-Christian medical doctors. These knowledge systems were also developed against the background of an oppressive society in which black and disabled people were totally marginalised. This created a situation not only in which not only did people without disabilities speak on behalf of people with disabilities, but whites spoke on behalf of blacks when forming the curriculum for training of occupational therapists.

This is particularly important because both our foundation and such a large portion of our history were strongly influenced by the traditional positivist research methodologies which are undergirded by empirical science with its quantitative-reductionist approach, its racist, sexist and class-based ideologies and overwhelmingly male research community⁴⁰. South African history also necessitates that this thesis should question the scientific and purportedly value-free neutrality of positivism, because the knowledge

³⁸ Foster, Michele. Race, class and gender in educational research. In: Cooper, B. & Vance, R. (editors) (1999).

³⁹ Butchart, A. (**Objects without Origins: Foucault in South African Socio-Medical Science**. South African Journal of Psychology; Volume 27(2): 101-110

⁴⁰ Ibid

arising from it is so laden with social constructions and oppressive contaminations that it requires the corrective application of knowledge that emancipates, and increases an awareness of the contradictions and distortions of the past. Feminism particularly questions the unnatural power relations to which positivist paradigms lend themselves, which lead to the *objectification* by the researcher of those participating in the research.

Occupational therapy is a relatively young profession that came into its own around the end of the 19th century and beginning of the 20th century. It is also a complex profession that addresses enabling approaches both to community and individual health and wellness through occupation through encouraging the acquisition of competencies and skills (Wilcock, 2003)⁴¹. Because of its holistic approach, complexity, female-based and generally broad-minded and progressive outlook; as well as its location within the conflicts of this particular historical time and context in South Africa, I believe that occupational therapy is amenable positioning within a broad social theoretical landscape in which critical theory and a feminist bias are paramount. We have to move out of our passivity and become more assertive, questioning, challenging and probing professionals if we are to survive.

As a largely female community of researchers concerned with the intimate and private lives of the people with disabilities that we serve, we need to engage with the question of how to proceed in academic research, where the theoretical, conceptual and formal traditions in which we are located are predominantly 'public' and 'male-stream'. Furthermore, such engagement is vital because as a predominantly women's profession, without a comparatively substantial body of empirical evidence, occupational therapists (and particularly South African OT's) have tended to be relegated to the edge of public, mainstream and academic concern⁴².

Therefore, garnering the views of my colleagues on their perceptions about the current state of occupational therapy in South Africa necessitated a method that was collectivistic rather than individualistic; one that would focus on the multivocality of the

⁴¹ Wilcock, A. (2003). Occupational science and occupational therapy – A discourse at Deakin University, Geelong, Australia. WFOT Bulletin. Volume 47: 28-31.

⁴² Ribbens, J. & Edwards, R. (1998). **Feminist Dilemmas in Qualitative Research**. Sage Publishers.

women concerned⁴³ and which was minimally threatening and maximally facilitatory. This approach was also a means of gaining insight into the lived reality of contemporary occupational therapists in order to theorise more ably how the past had impacted upon their present; to further theorise change, and break any silences that had been inherited from that past.

Cultural feminist scholarship believes that established research methods privilege “masculinist” ways of thinking and therefore aims to promote other modes of knowledge that allow for women’s voices to be heard. This thesis will reveal, through a cultural feminist lens, that expert knowledge (in this case occupational therapy’s knowledge), has been socialised by masculinist technical rationality, (in this case medical model knowledge) and that our “*own intelligence and centre of knowing*” have not been socialised (Fendler, 2003:19)⁴⁴.

The thesis will also demonstrate how occupational therapy in South Africa is historically a marginalised profession, based upon a western Eurocentric epistemology, working largely with previously disadvantaged and marginalised people (i.e. Africans, and people with disabilities). As a result our dilemma is this: as long as we are seeking to be heard by a public academic audience, we cannot evade the necessity to interpret the worlds and understandings of the “other” into a discourse or knowledge form that can be heard and understood within the dominant western frameworks of knowledge and culture. These third world/dis-abled/other voices cannot be heard by a western audience without the researcher being the “*interpreter, which is the inescapable nature of its dominance*” (Ribbens & Edwards, 2003:3)⁴⁵. Possibly, the effects of the profession also having been marginalised might create in occupational therapists a more humble, sensitive and respectful interpreter.

Occupational therapy urgently needs research that brings to the forefront the voices of these excluded and marginalised groups as the subjects rather than the objects of research, and research which attempts to understand the world better in order to change

⁴³ Madriz, E. (2003) Focus groups in feminist research. In Denzin, N. & Lincoln, Y. (2003). *Collecting and interpreting qualitative materials*.

⁴⁴ Fendler, L. (2003). **Teacher reflection in a hall of mirrors: Historical influences and political reverberations**. *Educational Researcher*. Volume 32(3): 16-25.

⁴⁵ Ribbens, J & Edwards, R. (1998). **Feminist dilemmas in qualitative research**.

it⁴⁶. In the South African context, these groups include not only those mentioned in the previous paragraph, but also the previously marginalised other than White/European cultural groups, such as majority ethnic African groups, the smaller minority groups such as the Indian, and people of mixed race in South Africa, who have always formed our 'patient' profile and are changing the face of our occupational therapy student profile. The patriarchal influences within our development not only imposed an important form of domination of our knowledge system but, as bell hooks (1989:22)⁴⁷ warns, '*patriarchal domination shares an ideological foundation with racism and other forms of group oppression*': hence, apart from reclaiming our own knowledge base we must reclaim our liberty as a proudly diverse group of South African occupational therapists.

Given our particular history, I believe that there has not been enough research effort on the part of our profession to adequately identify the specific, idiosyncratic needs, roles, perceptions and expectations related to human occupation and disability, of the various cultural groups that constitute the South African population. Nor has there been enough research to establish particular learning and educational needs of these groups in training within the profession, especially those whose educational grounding has been particularly disadvantaged as a result of apartheid.

Because of the historical and patriarchal nature of occupational therapy's parenthood, this research project has had to be constantly sensitive to how relations of gender and power have permeated all aspects of the developing life of the profession. The use of a reflexive autoethnographical approach has made it possible for me to step inside and outside of the past as *agent, culprit and victim* and reflect deeply on the consequences that this past carries with it.

Finally, the thesis must look at how we are all conditioned by our life experiences, which taints our neutrality as teachers, learners and affects the recipients of our services.

⁴⁶ Humphries B (1997) **From critical thought to emancipatory action: Contradictory research goals**. Sociological Research online. Volume 2(1): 1-13.
<http://www.socresonline.org.uk/socresonline/2/1/3.html>.

⁴⁷ hooks, bell. (1989). **Talking back: thinking feminist, thinking black**.

The next chapter will provide a description of the methodology used to collect and analyse the data for this thesis before it continues with the historical exploration and discussion of the findings from these sets of data.

CHAPTER TWO

Method of Travel and Instruments of Navigation

Route map: This chapter will motivate and present the research approach used, and briefly describe the data sets that were gathered; how, why and where they were gathered, and how they were analysed. It will explain how the theoretical framework that was selected influenced the process and nature of data selection and analysis. It will explain the explicit link between the theoretical framing, data production and data analysis processes.

Motivating the paradigm

The journey into this thesis has necessitated a deep and relentless interrogation not only of the researcher's genealogy and history but also that of the profession of occupational therapy within the South African context. Accordingly, the use of conventional empirical, positivist methods that tend to marginalise value issues, insist on neutrality, objectivity, observable facts and transparent descriptions, and a clear distinction between the interpreter and interpreted¹ would be out of place. Deep-rooted delving and reflection is a personal and sometimes painful process, a *warts and all* process. It is also often an emotive process that at times may necessitate the sacrifice of objectivity for the retention of the richness and complexity of subjective experience and expression.

My reality within this research must essentially take on multiple images: as child, as sister, as colleague, as person, as researcher, as therapist, as white South African woman, as academic, and concomitantly as agent, culprit and victim. Each with its own set of perspectives and each revealing another aspect of the reality that constitutes Robin's version of the truth as revealed through her interpretation of the data.

Thus, using a qualitative research approach, I have tried to locate myself within the developing world of occupational therapy in South Africa and have used material and interpretative practices that will make this world more visible² and, hopefully, more meaningful. Hence, a wide variety of data sources have been used to access the

¹ Lather, P. Reinscribing otherwise: The play of values in the practices of human sciences. In: Guba, E (Editor). (1990).

² Denzin, N. & Lincoln, Y. **Introduction: The discipline and practice of qualitative research.** In: Denzin, N. & Lincoln, Y. (Editors). (2003).

information needed to answer the critical questions, and these will be discussed later in this chapter.

The thesis is essentially a theoretical exploration of the development of the profession of occupational therapy in South Africa, using a range of conceptual arguments which will take the reader through a bricolage³ of different data sources, perspectives and revelations that result in an evocative and provocative reasoning which the researcher feels is essential in emancipating the profession from an historical bondage that has reined its potential to run free and become its own.

The process of deciding on data sources, data gathering and analysis was influenced by the particular theoretical and paradigmatic stages that I have alluded to in Chapter 1. For the most part, it was a very dynamic and, at times, an opportunistic one in which the (re)searcher was constantly surveying and scanning the environment for opportunities to gather relevant information that would feed into the continuous and complex process that would ultimately bring this thesis to a conclusion. It was an iterative process of moulding and building upon the ideas and thoughts that were evolving and emerging through the many interactions with others, reading a seemingly endless pile of documents, books and journal articles, attending conferences and symposia, gathering analysing and engaging with one set of data, reflecting upon it and then starting the process all over again with another set. And, towards the end, returning to some of the sets of data and reviewing them through another lens, only to discover new perspectives.

During most of the stages of data gathering a predominantly theoretical sampling process was used in which the data was collected for generating theory, and in which I jointly collected, coded and analysed the data in order to inform my decisions as to what data to collect next as the theory emerged from each set of data⁴. This sampling is thus done *“on the basis of emerging concepts, with the aim being to explore the dimensional range of varied conditions along which the properties of concepts vary”* (Strauss & Corbin, 1998:73)⁵.

³ Ibid.

⁴ Glaser, B. & Strauss, A. Theoretical sampling. In Glaser, B. & Strauss, A. (1967), *The discovery of grounded theory – Strategies for qualitative research*. Aldine Publishing Co. Chicago

⁵ Strauss, A. & Corbin, J. Basic operations - asking questions and making comparisons. In Strauss, A. & Corbin, J. (1998).

As such, while it was essential to plot out an initial data gathering and analysis plan, it was impossible to become too rigidly bound within this plan because too many opportunities arose during the process which were too good to lose in terms of bouncing developing thoughts off others and gaining opinions about these thoughts, or listening to some of the relevant voices of the many people who make up this complex and beautiful country.

As I immersed myself in this research it became an integral part of many of the daily interactions and situations occurring within and outside of my work. It is thus difficult to say where data gathering actually began and where it ended, because it is possible that right up to the last chapter of this thesis, there might still be conversations with others that could influence a word or a thought that will ultimately contribute to its final outcome.

It is, however, important to stress here that the process was not some sort of frivolous gamble, in which lady luck was the hostess. The framework was carefully plotted and the building blocks, of many varieties, were put in place as I progressed; some were also discarded as the emerging theory suggested their inappropriateness to the exploration. The tabulated summary of events and sources of data that is provided in table 2 on page 37 will hopefully illustrate how this occurred.

Data production and sources

1. Fieldwork data

The early phenomenological phase of data gathering was aimed at accessing data that revealed phenomena related to the changing face of the profession of occupational therapy, and these included the following:

a) SAQA Submissions:

One of the post-apartheid government's primary goals was to transform tertiary education in South Africa from the elitist, exclusionary and inaccessible form it had taken, to one which addressed the economic demand for greater numbers of skilled professionals, and to contribute to the *"socialisation of enlightened, responsible and*

constructively critical citizens” (UDW, circa 1999:1)⁶. Part of this project entailed the introduction of a single qualifications framework for the development and provision of higher education qualifications within a single coordinated higher education sector⁷. The focus of transformation was upon outcomes-based and programmes-based curricula and was recommended by the National Commission of Higher Education (1996)⁸ and the White paper 3: A programme for the transformation of higher education (1997)⁹.

As part of this process, the South African Qualifications Authority (SAQA)¹⁰ was established to oversee the development and implementation of the National Qualifications Framework (NQF), which was essentially the vehicle for transforming higher education and training in South Africa and for acting as a quality assurance system for the development and registration of standards and qualifications¹¹.

The various registering bodies responsible for establishing education and training qualifications were recognised by SAQA as sources of expertise in sub-fields such as health, and these bodies are referred to as Standards Generating Bodies (SGBs). The functions of Standards Generating Bodies (SGBs) are *inter alia* to generate qualifications and standards according to SAQA requirements; to update and review qualifications and standards, and to recommend criteria for assessors and to perform any other function delegated by the National Standards Bodies of SAQA¹². In this way the Professional Board for Occupational Therapy and Orthotists and Prosthetists of the Health Professions Council of South Africa (HPCSA) has become an SGB for the training of occupational therapists in South Africa.

⁶ University of Durban-Westville (circa 1999), A brief Guide to Understanding SAQA and the NQF. University of Kwa-Zulu Natal. Durban.

⁷ The Higher Education Qualifications Framework, Policy issued under the Higher Education Act, Act No.101 of 1997, (Draft Discussion) July, 2004.

⁸ The National Commission for Higher Education (1996)

⁹ The White Paper 3. A programme for the transformation of higher education. General notice 1196 of 1997. Government Printers, Pretoria 0001.

¹⁰ The National Qualifications Framework and the Standards Setting (July, 2000), SAQA Postnet Suite 248, Private Bag X06, Waterkloof, Pretoria 0145

¹¹ *ibid*

¹² Kelly, Maire. (2004). Power point presentation at a workshop of the Standards Generating Working Group, Professional Board of Occupational Therapy and Medical Orthotics and Prosthetics, Health Professions Council of South Africa. Burgers Park Hotel. Pretoria, 2nd and 3rd of December.

In 1999, the process required that all tertiary institutions should provisionally register existing degrees, providing an outline of the purpose, entrance requirements, outcomes and competencies and assessment criteria for each degree. This registration of qualifications was used as the first step in a process of evaluating whether existing qualifications were at least minimally adapting to an outcomes based curriculum. As such it required that the qualifications that were submitted presented the most recent outline of their curricula. These early submissions were commonly referred to as **the SAQA submissions**.

As researcher, I reasoned that an analysis of the SAQA submissions of the eight occupational therapy degrees offered in South Africa would provide adequate and sufficient data for the compilation of a profile of the current and up-to-date competencies expected of graduating occupational therapists in South Africa.¹³ All eight universities¹³ training occupational therapists were thus requested to submit to the researcher copies of their SAQA submissions and all eight responded to this request.

The report that was generated from the results of the analysis of these 8 documents together with the results of the analysis of the Focus Groups (see point b below) then formed a package that was later distributed electronically to the Resonance Groups (see point c below) for their feedback (refer to Appendix H).

Unbeknown to me at that time, I was later to become part of the process of setting standards and criteria for occupational therapy's programme accreditation. In late 2004, I was invited by the Professional Board for Occupational Therapists, Orthotists and Prosthetists of the Health Professions Council of South Africa (HPCSA) to become part of their Standards Generating Body's working group (see Appendix B). This group was given the task of drawing up the exit level outcomes and assessment criteria for the occupational therapy technical, undergraduate and postgraduate qualifications in South Africa that would be used to guide the next set of SAQA submissions. How my appointment onto this task team fits into the holistic plan of this thesis will be revealed in point e. page 33.

¹³These are the Universities of Cape Town, Free State, Durban-Westville (which has subsequently merged with the University of Natal to become the University of KwaZulu-Natal), the Medical University of South Africa, Pretoria, Witwatersrand and Western Cape.

b) Focus Groups:

Four focus group meetings of approximately an hour long were held in Gauteng (2), KwaZulu-Natal (1) and the Free State (1). The participants consisted of a multiracial group of mostly young and middle-aged occupational therapy clinicians and lecturers. In each of these focus groups the following four core questions were asked:

- ❗ *Do you think there have been changes in the role and scope of occupational therapy over the past 20 years?*
- ❗ *Do you believe the demands in clinical reasoning and clinical competence have changed over the past 20 years?*
- ❗ *Do you believe that as occupational therapists in South Africa we have something unique to offer the rest of the world?*
- ❗ *Do you think the current methods used in occupational therapy training centres in South Africa adequately assess the competencies required of the student graduating as an OT?*

A summary of the demographic details of the focus groups can be found on page 29 in Table 1 below; details of each specific focus group can be found in Appendix C.

Limitations Although coordinators had been identified in advance at the various sites where the focus groups were held, and specifically tasked with selecting a group of participants that would provide an equitable mix of race, age, status and field of practice and include a spread of academics versus practitioners, this did not always occur due to the lack of availability of such a mix/spread on the days that I was at the various sites where the focus groups were held. The focus groups thus came to represent the currently shifting but still powerful hegemony of the dominant white occupational therapists.

However, when comparing the 2004/2005 demographic profile of occupational therapists registered with the Health Professions Council of South Africa, the overall focus grouping is relatively representative of a microscopic sampling of the South African occupational therapy profile, see column 4 in Table 2. The focus groups thus have a greater weighting of race groups other than white than are registered with the HPCSA.

Ethical issues Participants were invited to participate voluntarily in the Focus Groups. At the commencement of each focus group, participants were requested to sign written consent to participate in the group and were assured of anonymity.

c) Resonance Groups:

The term *resonance groups* was coined by the researcher to describe a group of occupational therapy colleagues from all over South Africa, both clinical and academic, who agreed to act as a sounding-board through the email, and from whom the researcher *bounced* off the initial findings of the analysis of the SAQA submissions and the analysis of the focus groups. Of the thirty individuals who were approached, either at exploratory meetings or during the focus groups, and who were invited to become part of the resonance group, twenty indicated their willingness to continue and were sent the documents on these analyses. Only twelve of these twenty finally responded to my request for comment. The demographics of this group can be found in Appendix C, but in summary, they consisted almost exclusively of white, middle-aged, female academics.

Each participant was electronically sent the package containing the initial findings analysis of the SAQA submissions (Annexure 1) and the Focus Groups (Annexure 2)¹⁴ and was asked to comment according to the following questions:

- ❓ Do you think the information contained in Annexure 1 (i.e. Analysis of SAQA Feedback) adequately represents the final competencies required of a graduating occupational therapist? Please qualify your reasons for agreement or disagreement.
- ❓ Bearing in mind the methods you are acquainted with which are used in assessing final competences of graduating occupational therapists (e.g. case studies, written tests/exams/OSPES etc) do you think they would be adequately able to assess all the competences listed in Annexure 1? Please motivate your answer.
- ❓ Do you think the findings of the analysis of the focus groups (Annexure 2) are a realistic reflection of where occupational therapy in South Africa is today? Please motivate your answer.
- ❓ What do you think constitutes professionalism in South Africa?

¹⁴ These annexures can be found in Appendix H.

- ❗ Please also add any additional comments or views that may have arisen for you while reading these documents.

This method of data collection was an extremely efficient and useful one in that it was possible to transfer large quantities of information (a 22-page document) electronically to participants at minimal cost and very quickly; to obtain their feedback electronically, thus also avoiding postal expenses and delays; and to transfer the respondents' comments on the relevant questions, using a quick and efficient cut and paste method, from their email onto a pre-prepared first phase analysis document. The process of analysis will be discussed in more detail under the section on analysis in this chapter, pages 44 to 48.

Ethical issues

Participants were initially invited verbally to voluntarily participate in the resonance groups and were under no obligation to do so. They were informed that after they had had the opportunity to give this their consideration I would follow up with an electronic request for their answer. In this way participants had time to make their decision. Thereafter electronic contact was made with each participant again inviting their voluntary participation, each of those who agreed was requested to sign written consent to participate in the group and assured of anonymity.

As discussed in Chapter 1, the aim in using the first three sets of data i.e. SAQA submissions, focus groups and resonance groups, was originally to establish the status of the current broad occupational therapy curriculum and to obtain the opinions of a wide diversity of South African occupational therapists on phenomena relating to the changing role and scope of the profession, and the applicability of current training in addressing these changes. It was only after analysis of these sets of data, together with the perusal of the HPCSA statistics of registered therapists that the detour away from the phenomenological theoretical framework was taken.

These four sets of data thus became pivotal in contributing to the first part of the emerging theory by providing evidence of the dominance of *medical model and Eurocentric* ideology in the occupational therapy epistemology. This evidence required a theoretical shift that would necessitate co-construction of data, deeper understanding of the positionalities of the research participants and clearer insight into the

blockages/hindrances that impact upon and influence the agent/culprit/victim status of the researcher and the researched.

Up until this stage analysis had been primarily based on the model of grounded theory using a mainly phenomenological lens. It was at this stage that the route the research was taking changed, and it was only after this that the feminist, Foucauldian and critical theory lenses became actively operational in data analysis.

TABLE 1: SUMMARY OF DEMOGRAPHIC BREAKDOWN OF FOCUS GROUPS WITH A COMPARATIVE PROFILE OF THERAPISTS REGISTERED WITH THE HEALTH PROFESSIONALS COUNCIL OF SA¹⁵

	Focus group totals		HPCSA ¹⁶ Registrations Oct 2004	
	Numbers	%	Numbers	%
1. Race: African	4	19%	113	4,34%
Indian	3	14,28%	93	3,58%
White	13	61,90%	983	37,79%
Mixed	1	4,76%	31	1,20%
Unknown			1381	53,09%
Others ¹⁷				
Total	21	100%	2601	100%
2. Gender: Female	19	90,48%	2505	96,31%
Male	2	9,52%	96	3,65%
3. Age range: 20-29	8			
30-39	5			
40-49	4			
50-60	2			
>60	1			
4. Work Status				
Practitioner	4			
Academic	12			
Both	5			
5. Field: Physical	12			
Psychiatric	9			

¹⁵ These data sources were obtained from the focus group tallies (columns 2 and 3) and the numbers of registered occupational therapists (columns 4 and 5) were calculated from information sent to me by the HPCSA on their registrations of occupational therapists as of October 2004.

¹⁶ These columns represent the numbers and percentages of the racially demographic profile of occupational therapists registered with the HPCSA as at October 2004.

¹⁷ Other/ unknown in this context refers to those occupational therapists registered with the HPCSA who have not indicated their race group. This thus implies that this grouping represents OT's from all race groups, however in Joubert R's (1997a) research for a Masters degree the HPCSA statistics for the period 1995-1996 indicated that White registrations was in the region of 93%, it is thus still likely that a large percentage of this unknown category are whites which would bring the above HPCSA percentage closer to 60% or even greater.

2) Textwork data: Historical and current relevant documents

Emerging theory from the sets of data describe in point 1) above suggested that it was essential to explore relevant historical documents in order to establish how the socio-political milieu of the 'birth days' of occupational therapy impacted upon its epistemology. Thus the motivation behind selecting these various historical documents was:

- To explore the history of the development of occupational therapy in South Africa in order to establish factors that had impacted upon the epistemology. This also included a review of the statistics of therapists registered with the HPCSA to establish if the past profile of predominantly white females had changed (see Table 1, page 29 above).
- i) To explore relevant past policy and legislation during the time of the early development of occupational therapy in order to establish sources of power and document/monument¹⁸ interplay which influenced this epistemology and compare these against current, relevant government policy, legislation and attitude (see page 32 point d).
- ii) To explore relevant past documents expressing the attitude of the apartheid government towards people with disabilities and compare this with the current Government's documentation on policy and attitude towards people with disabilities. This helped to establish and position occupational therapy's birth within a particular enclosing structure of forces and barriers that largely dictated the epistemology. The comparison with current ANC policy and attitude helped to give direction to the establishment of a new more appropriate epistemology (which was revealed in the current draft documents on standards and assessment criteria for the training of occupational therapists discussed on page 33).

The juxtaposition of past and present legislation points to the shifting discourse within Health Professions at a legal policy level. Whether and how these policy discourses influence occupational therapists' thinking and practice is the focus of the latter data production strategies.

¹⁸ Refer to Chapter 1 page 14.

a) Joan Davy's¹⁹ historical record of the first 50 years of the professional association of occupational therapists proved an invaluable source of information. Mrs Joan Davy was one of the pioneer occupational therapists who was part of the group that were responsible for establishing occupational therapy as a profession in South Africa. For many years she compiled an historical record of the professional association of occupational therapists (then referred to as the South African Association of Occupational Therapists or SAAOT) from 1945 until 1994 when the association changed its name to the Occupational Therapy Association of South Africa (OTASA). This document has been invaluable in plotting out the progress and influences upon occupational therapy, particularly in its formative years, and was probably the most influential in confirming the theory of patriarchal control over the occupational therapy epistemology, pointing to the need for accessing the relevant government documents described in c) and d) below.

b) Various journal articles and book chapters in which the history of occupational therapy in South Africa and the rest of the world (particularly the United States and United Kingdom) was described. These were: The Initiation of Occupational Therapy in South Africa (Dart, 1962)²⁰; An Approach to Occupational Therapy (Jones, 1977)²¹ Occupational Therapy in Rehabilitation, its History and Place in the Health and Social Services of Today (Mc Donald *et al* 1978)²², The Past and Future of Occupational Therapy in South Africa (Tobias 1982)²³; The Occupational Therapy Context: philosophy, principles and practice (Baum and Christiansen, 1997)²⁴; An Occupational Perspective of Health (Wilcock, 1998)²⁵ and The History of Occupational Therapy (Schwartz, 2003)²⁶. Apart from providing valuable historical information many of the old South African Occupational Therapy Journals also revealed the discourse of those times

¹⁹ Davy, J. (2000). **The history of the Occupational Therapy Association of South Africa.** OTASA Office. Box 11695, Hatfield 0028 RSA.

²⁰ Dart, R.A. (1963). **The initiation of occupational therapy in South Africa.** South African Journal of Occupational Therapy. Volume 1(8): 4-6.

²¹ Jones, M. and Jay, P. (1977). **An approach to occupational therapy.** Butterworths. London.

²² MacDonald, E.M. MacCaul, G. Mirrey, L. & Morrison, E. (1978). **Occupational therapy in rehabilitation.** Balliere Tindall. London.

²³ Tobias, P.V. (1982). **The past and future of occupational therapy.** The Vona du Toit Memorial Lecture. South African Journal of Occupational Therapy. Volume 12(2): 6-18.

²⁴ Baum, C. & Christiansen, C. The Occupational therapy context: Philosophy-principles-practice. In Christiansen, C. & Baum, C. (Editors). (1997).

²⁵ Wilcock, A. Introduction. In: Wilcock, A. (Editor) (1998).

²⁶ Schwartz, K.B. The History of Occupational Therapy. In: Crepeau, E. Cohn E. & Boyt Schell, B. (Editors). (2003).

and contributed to the emergence of the theory of patriarchy over occupational therapy's epistemology.

c) Various relevant government documents from the apartheid days. These were: the South African Medical and Dental Council's Medical, Dental and Supplementary Health Service Professions Act 56 of 1974²⁷; the Regulations Relating to the Constitution, Functions, Powers and Duties of the Professional Board for Occupational Therapy (1976)²⁸; various volumes of "Disability in the Republic of South Africa"²⁹ (1987); The Historical Failures and Accomplishments of the Western Medical Model in the Third World (Werner and Saunders, 1997),³⁰ Crepeau et al (2003)³¹.

d) Current relevant post apartheid documents.

The African National Congress's³² National Health Plan for South Africa (1994)³³

The White Paper on an Integrated National Disability Strategy (INDS)(1997)³⁴

The INDS is the product of an intensive and thorough democratic process of consultation with all the relevant organizations of and for disabled people. It represents the Government's thinking about what it can contribute to the development of disabled people and to the promotion and development of their rights. It was thus used to "*kick-start a further process, involving disabled people in the development of policies and*

²⁷ South African Medical & Dental Council (SAMDC) : Medical, Dental and Supplementary Health Professions Act, 1974 (Act 56 of 1974)(As amended) – Statutes of the Republic of South Africa – Medicine, Dentistry and Pharmacy. Pretoria.

²⁸ South African Medical & Dental Council. The Regulations Relating to the Constitution, Functions, Powers and Duties of the Professional Board for Occupational Therapy (1976) No. R 2287 of 3 December 1976:278 – 323.Pretoria.

²⁹ Disability in the Republic of South Africa. (1987). **Volume 3: Treatment.** The Co-ordinating Committee: Year of Disabled November. Department of National Health and Population Development. Pretoria.

³⁰ Werner, D. & Saunders, D. The historical failures and accomplishments of the western medical model in the Third World. In: Werner, D. & Saunders, D. (Editors). (1997).

³¹ Crepeau E.B, Cohn E.S and Boyt Schell B (editors) (2003) Willard and Spackman's Occupational Therapy,

³²The African National Congress came into power in April 1994 as the first democratically elected Government of South Africa after the demise of apartheid.

³³ African National Congress (ANC). (1994). **A National Health Plan for South Africa.** Prepared by the ANC with the technical support of the World Health Organisation and UNICEFANC. Johannesburg.

³⁴ **An Integrated National Disability Strategy (INDS).** (November 1997). The White Paper of the Office of the Deputy President. Rustica Press. Republic of South Africa

legislation aimed at giving effect to the recommendations”³⁵ contained in this white paper.

The first of these two sets of documents was used by the researcher as a yardstick against which to measure the visions and aspirations of future health care planners in South Africa with those of the past, while the second of these documents was used particularly to compare the current attitude of health professionals and Government structures towards people with disabilities in South Africa to those of the apartheid era. The documents from the apartheid era that were used for this comparison were a selection of volumes (ironically, published exactly ten years previously, in November 1987) collectively falling under the title, *Disability in South Africa*. These documents will be described under point 5 below i.e. Historical documents.

e) Draft documents on standards and assessment criteria for the training of occupational therapists.

The documents compiled by this SGB working group (discussed on page 26 above) for registration of the occupational therapy degree with SAQA in 2006 are, at the time of completing this research, currently in their last phase of circulation to stakeholders³⁶ for feedback before they become finalised. In this penultimate stage it is unlikely that they will undergo drastic changes before they are accepted as complete.

It was possible to use these 2006 documents for comparison against the analysis of the original SAQA submissions of 1999; in this way they have provided a valuable barometer for gauging the degree of change that has occurred in the broad occupational therapy curriculum over the past 6-odd years.

In addition to this, the World Federation of Occupational Therapists (2002) Revised Minimum Standards for the Education of Occupational Therapists was used for a global comparison of training standards.

³⁵ Mbeki, T. (1997) Foreword. In: An Integrated National Disability Strategy.

³⁶ Apart from being compiled by a group of occupational therapists representative of all training centres, communities, clinicians and occupational therapy assistants, these documents have also already been placed on the internet for comment by stakeholders such as organisations for people with disabilities and other health professional groups.

3. Statistical data

A statistical breakdown of qualified occupational therapists, according to race and gender, who are registered with the Health Professions Council of South Africa (HPCSA) as at 25 October 2004. (See columns 4 and 5 in Table 1 page 29)

This document was emailed to me on request from the HPCSA and made it possible to obtain a broad racial and gender profile of occupational therapists currently practising in South Africa. This set of data confirmed the theory of a predominantly white, female, South African occupational therapy profile.

4. Narrative data: Life stories of people with disabilities

Based upon personal recollections from discussions with disabled activists in South Africa, and during the progress of the literature review for this thesis, it became clear that both locally and globally there was substantial disenchantment amongst people with disabilities about the attitude of health professionals towards them, and research done about them (Finkelstein, 1980; Finkelstein, 1981a; Finkelstein, 1981b; Jagoe circa 1988; Miles 1996; Shakespeare & Watson 1997; WHO, 2001a and 2001b; Oliver 2002; Barnes and Mercer, 2004; Masakhwe, 2004).³⁷

The researcher therefore felt it was important to explore the attitudes of people with disabilities regarding their experiences of being disabled in South Africa in the apartheid years, more specifically, experiences related to their rehabilitation. Two individuals, both men, were approached to provide an account of their experiences. The reason for choosing these two men was that they fulfilled most aptly a profile of what can historically be considered as the most oppressed group of people in South Africa i.e. poor, black, and extremely disabled.

While it would have been more desirable to have obtained the participation of two disabled women, since gender constitutes yet another category of oppression, category, the above two men were selected from a convenience point of view for a variety of reasons. I knew one of them well and had seen the other on regular trips to one of the areas I worked in, so I was relatively well acquainted with the extent of both their disabilities. I was also well known in the area, having undergone a process of negotiated

³⁷ See Bibliography page 310.

community entry with the *inkhosi*³⁸ of that area in the early 1990's in order to use its resources for student training, as well as having worked there for over 10 years. The lived experiences of these two men of being disabled and the support provided, or lack thereof are pertinent to an understanding of the recipient's views of the health professions and services in South Africa. Their participation is thus in accordance with the research study's goal of gaining insight into the world of occupational therapy/ rehabilitation and Health Services from varying standpoints.

The first is Sam³⁹, is a young man approximately 21 years old, who has had severe athetoid cerebral palsy since birth, making it impossible for him to do virtually anything without assistance. He also has serious speech articulatory problems. He comes from a semi-rural area, living on a disability grant in relative poverty but with both parents earning a small income. He was at a special school and has achieved adequate computer and writing literacy skills to write his own story. Sam was requested to write his story containing responses to the following:

- Who I am.
- What my disability means to me as a South African.
- My experiences of rehabilitation and of occupational therapy.
- Other things that I think are important to mention.

Sam was particularly requested to be very honest about what he was expressing, and not to be concerned whether what he said would offend or upset me or anyone else who read it. His response to this request was a six-page essay written in **Times New Roman bold font size 14**. A detailed exploration of this response is provided in Chapter 9.

The second, Khulu⁴⁰, was initially selected for interview as a consequence of my sheer curiosity and amazement at his feats, given the observable extent of his disability, and hence this begged the question as to what kind of rehabilitation he had received. I had passed him on the road on several occasions, pulling himself along very steep contours, by his hands on a skateboard. Khulu comes from the same area as Sam but is older, approximately 38 years old, is illiterate and survives on a disability grant and the money

³⁸ Zulu name for the highest level of traditional community leadership.

³⁹ Fictitious name

⁴⁰ Fictitious Zulu name meaning "Big".

he makes through begging. He has partial use of his upper limbs and no use at all of his lower limbs. I am uncertain of the cause of his disability or the exact *diagnosis* of it but it would appear from observation that he has tetraplegia⁴¹, possibly as a result of poliomyelitis.

Khulu was interviewed in his home after he had agreed to allow me to do so. A male community rehabilitation facilitator (CRF) who was known to Khulu acted as my mediator and, once Khulu's permission to be interviewed had been obtained, later acted as interpreter. The interview was a developmental type, which took the form of a few pre-planned, open-ended questions but also made use of additional probing as opportunities arose during the interview. I had originally planned to tape-record the interview but at the last minute decided against both written and taped recordings because I did not want to alarm him or break the important one-on-one interaction with him by having a recorder on hand or constantly writing things down during the process, I did jot down in a notepad one or two key aspects such as date of birth, age of onset, but the rest was based upon an open conversation between myself, Khulu, his sister-in-law who joined us, and the interpreter.

On returning to my car, I jotted down more key elements and stored the rest in my memory. It was necessary for me to return a second time to interview Khulu in order to clarify certain aspects. For example I had not obtained adequate details about his hospitalisation and rehabilitation during the first interview and had forgotten to ask whether he had a disability grant, and whence he had obtained the skateboard.

The questions which formed the basis of our interviews were:

- ❗ Tell me about your history, where were you born? (Probes were included during the course of the interview as the need arose to obtain more information)
- ❗ What happened to you, how did you become disabled? (During this process quite a lot of probing into this part of his history was necessary such as: how old were you when it happened? What were the symptoms of your illness? Did you go to hospital and did you have rehabilitation while in hospital? Where did you get your skateboard?)

⁴¹ Three out of four limbs are paralysed.

¶ I often see you climbing up the mountain on your skateboard. Do you get from this house to the road on your own without help? (Probes: Where are you going to when I pass you? What do you do when you get to your destination? Where do you sleep at night when you are away from home? Do you get a disability grant?)

(A detailed description of Khulu's story can be found in Chapter 6 which is followed by a *speculative analysis*⁴² of what would have been the likely outcome had Khulu had intensive rehabilitation during the particular historical time of onset of his illness/disability)

Ethical Issues

Both Sam and Khulu (in Zulu) were verbally informed that if they gave their consent, their stories would be used as data for my research but that they would remain anonymous. Both agreed and Sam, who is unable to write with a pen, asked his parents to sign on his behalf, Khulu asked the interpreter to sign for him as he is unable to read or write (see Appendix D). On completion of the interview/essay each was given an honorarium of R50. They were not informed beforehand that they would receive an honorarium, in order not to influence their decision to participate.

⁴² This is defined and discussed on page 57 of this chapter.

TABLE 2: TABULATION OF THE VARIOUS DATA SOURCES COLLECTED, THEIR PURPOSE AND THE INCREMENTAL INFLUENCE OF ONE UPON THE OTHER.

(The black arrow on the table below indicates the point at which the focus of research changed and the shaded area denotes the phenomenological phase of data gathering. The non-shaded area denotes the feminist, Foucault and critical theory phase of data gathering and analysis)

DESCRIPTION OF DATA AND SEQUENCE	SOURCE OF DATA	PURPOSE FOR WHICH IT WAS GATHERED	INFLUENCE UPON EMERGING THEORY
1. SAQA Submissions ⁴³	All 8 universities training occupational therapists in South Africa.	To draw up a profile of the final competencies expected of qualifying OT's ⁴⁴ .	Guided some of the core questions for the focus groups
2. Focus groups	2 groups in Gauteng Province 1 group in the Free State 1 group in KwaZulu-Natal.	To obtain the perceptions of a diversity of South African OT's as to whether there have been changes within the profession and what these were, whether there was a unique South African occupational therapy identity and whether training is concomitant with this.	Developing awareness of the conflicts between old entrenched perceptions of what role and scope of OT is, the historical influences upon it and what it should be, given the changes that are occurring in health care nationally and globally.
3. Resonance group ⁴⁵ feedback	A group of 12 OT's from all over South Africa but mostly white, mostly women and mostly in academic field.	To obtain a diversity of views on the findings from the analysis of data from 1 and 2 above.	Together with (1) & (2) above, had a pivotal influence upon the direction of this research because it confirmed my growing concern about the historical influences upon the current voice and discourse of OT in South Africa and directed me towards closer exploration of these influences.
4. Statistics of OT's registered with the HPCSA in Oct.2004	Health Professions Council of SA	To establish the current demographic profile of OT's in SA.	Confirmed the dominance of white females.
5. Historical documents	- Davy's (2003)⁴⁶ document on the first 50 years of OT in SA. - old SAMDC⁴⁷ rules and	To explore historical influences upon the development of OT in South Africa and how these are impacting	Confirms the strong influence of medical model ideology and the power exerted by patriarchal control



⁴³ The origins and purpose of the SAQA submissions are described in detail on pages 23-25.

⁴⁴ OT's is an abbreviation for Occupational Therapists

⁴⁵ Resonance groups are described in detail on pages 27-28 of this Chapter and in Appendix C.

⁴⁶ Davy J. (2000). **The history of the Occupational Therapy Association of South Africa.** OTASA Office. Box 11695, Hatfield 0028 RSA.

	- regulations for health professions other than medical professions. - Various Volumes of "Disability in the Republic of South Africa" – apartheid era records of the approach and attitudes of people without disabilities towards people with disabilities - Various historically relevant journal and book chapters on the history of OT locally and globally.	upon the current course the profession of OT is taking. These volumes were used for comparative purposes to study the disability discourses of Governments then as opposed to now. To substantiate and confirm and compare ideological influences impacting upon SA OT development	systems of the day. New insights lead to new data production strategy. Confirms the oppressive, racially biased, apartheid ideological attitudes and power structures used as the voices of people with disabilities Served to demonstrate some strong parallels and similarities between global and local development of OT
6. Post apartheid government documents	- Current HPCSA⁴⁸ documents and Government documents of Health Plans and transformation of health care. - The ANC's National Health Plan for South Africa (1994). - The Integrated National Disability Strategy (INDS) 1997. - Latest HPCSA draft of the purpose, rationale, exit level outcomes and assessment criteria for the B.Occupational Therapy degree.	To allow for comparisons between then and now and how the focus of health care in South Africa has changed.	Confirmed the presence of a legislative and policy milieu that far more appropriately mirrors the occupational therapy ethos of today and one that will provide an ideal compost for the establishment of a 'new' more appropriate and owned occupational therapy identity.
7. Life stories of people with disabilities	- Various Articles and Chapters written by disability activists and rights movements. - 2 life stories of relatively young men from economically and, previously	To gauge the perceptions of people with disabilities about the attitudes and quality of care they receive from health professionals. To explore the lives of two people with disabilities who became	Contributed to understanding the commissions and omissions within health care and rehabilitation of the past that have created animosity towards, and rejection of, health professionals and current models of health care. It also

⁴⁷ SAMDC stands for the South African Medical and Dental Council, which was in control of registration of occupational therapists in the apartheid era.

⁴⁸ HPCSA stands for the Health Professions Council of South Africa, which took over from the SAMDC after the demise of apartheid.

	politically disadvantaged, backgrounds.	disabled during the apartheid era and would thus have had/ not have had exposure to the health and rehabilitation services of that time.	heightened awareness of what needs to be changed to make the OT contribution more acceptable and meaningful. Heightened awareness of mistakes of our past and some of our current interventions.
8. Personal narratives	- Family documents, essays, letters and photo albums. - Own memory.	To provide a background of the researcher's own history and experiences and how these position her within the history as well as to reflect upon this history in the context of this research. Also to be transparent about the researchers own background.	Provided opportunity for deep personal reflection about my own role and roots within this history that enriched the understanding of 'other's' roles which were similar and different to mine because of our various socio-political situatedness at that time.
9. Seminars	4 lecturer/ facilitators and approximately 10 fellow D.Ed students and the feedback/critique that they provided at each seminar on the various aspects of this research which were presented at each seminar.	This was not purposefully gathered but feedback from these helped to enrich the developmental process of the thesis.	Helped to focus the researcher and make decisions about the appropriate data gathering instruments and theoretical framework for the research.
10. Meetings/ discussions with colleagues (See Appendix A)	8 meetings/discussions with mostly academic colleagues from all over South Africa and one from Canada	Not part of the original plan but these meetings and discussions were opportunistic and used to bounce theories arising off the various individuals.	Contributed towards refining thoughts and clarifying concerns around controversial issues.
11. Workshop (See Appendix E)	Held by the Occupational Therapy Department at UKZN ⁴⁹ with clinical OT's in public service.	To try and identify <u>niche areas</u> in occupational therapy.	Reinforced information coming out of focus groups and helped refine thoughts.
12. Attendance and presentations at conferences etc.	Three presentations at two local and one international (East African) conference.	To showcase aspects of the research at public fora and to test responses of audience to concepts.	All three presentations evoked a combination of positive and negative critique from the audience. This served as affirmation that the research was provocative and helped with refinement.

⁴⁹ University of KwaZulu-Natal

13. Publications	Currently two journal articles (local) have been published on aspects of the research and two co-authored book chapters.	To show case aspects of the research at public forums and to test the responses of the readership.	Similarly both have evoked positive and negative critique which has affirmed the controversial nature of the content of this thesis in its questioning of old entrenched ideologies. This also contributed towards refinement.
14. Most recent minimal standards of competencies for occupational therapists HPCSA and WFOT ⁵⁰	- WFOT (2002) minimum Standards of training occupational therapists. - Minimum standards draft Compiled by the Professional Board for OT, HPCSA (Standards Generating Body - see page 33 point e.)	To use for comparative purposes to see how the role and scope of the profession has changed since its early history.	Has contributed to the final thesis in demonstrating a resilience and adaptability in South African OT's but confirmed the need for more urgent transformation if the profession is to survive robustly in this country.

Testing aspects of the thesis and responding to the feedback

Seminar weekends

The School of Educational Sciences at the University of KwaZulu-Natal where I am registered for this Doctoral degree, runs an extremely laudable programme. For the first three years of registration they arrange seminar weekends every six weeks during the year. The purpose of these is to bring together a group of colleagues who are registered for the same degree, and use the time to prod, debate and guide them through the development of their proposals, theoretical frameworks, data gathering instruments, methods of analysis and write up. This process works on the basis of coming prepared to each seminar with a completed pre-set assignment, which forms a component of one's research. For example, one assignment required that we prepare an outline of our theoretical frameworks. This assignment is then presented to one's cohort group and critiqued by them and the three or four School doctoral lecturers who facilitate the process.

⁵⁰ The World Federation of Occupational Therapists.

Presentations, attendance at conferences and publications

During the progress of this research I took advantage of as many opportunities as I could to meet with appropriate colleagues outside of my own province, to present papers at conferences on aspects of the research or publish articles or book chapters. In this way I suggest that I was able to showcase aspects of the research in the public domain, obtain feedback and modify or supplement existing theorisation. This also provided a means to 'test' the process in progress and opened doors for me to gain new insights that would otherwise not have been made available.

Attendance and presentations, conferences and congresses included:

- The Ingede African Scholarship Conference at the University of KwaZulu-Natal held at the University of KwaZulu-Natal (UKZN) in March 2004. I attended selected aspects of this conference because it covered a lot on indigenous African knowledge.
- Arranging and facilitating a workshop entitled "Finding our Niche" held at the Occupational Therapy Department (UKZN) in July 2004. This was attended by local clinical and academic therapists from both the physical and psychiatric fields of occupational therapy. I shared some of the findings from the analysis of my focus groups with this group as a basis for group discussions in the breakaway groups held later. (Appendix E)
- Attendance at the Occupational Therapy Association of South Africa's (OTASA) Biannual Congress titled: *Doing things differently* held in Cape Town in May 2004. I also presented a paper at this congress which was based upon an aspect of my research, titled *Evidence Based Practice: does it work for the South African Context?*
- Attendance at the Occupational Therapy Africa Regional Group (OTARG) congress in Moshe, Tanzania from 15th to 19th August 2005 at which I presented a Keynote address titled: *Indigenous fruits from exotic roots, Designing an African Occupational Therapy Curriculum: Lessons Learnt from South Africa*. Appendix F)
- Presentation and partial attendance at the AstraZenica Research Symposium of the College of Health Sciences, University of KwaZulu -Natal, in September 2005, titled: *Indigenous fruits from exotic roots: revisiting the South African Occupational Therapy Curriculum - research in progress*. (Appendix F)

Journal Publications: I have managed to publish two articles in the South African Journal of Occupational Therapy:

- *Are we coming of age or being born again? How does this impact upon the education and assessment of competence of occupational therapy students in South Africa?* SAJOT November 2003, Volume 33(3): 2-4
- *Evidence Based Practice - A critique based upon occupational therapy within the South African Context.* SAJOT September 2005 Volume 35 No. 2 pp 8 to 13 (for example see Appendix F).

Book Chapters: Early in 2005 I was approached by a colleague from the University of Cape Town with whom I have had several discussions about my research and who was co-editing a new book titled: Practice and Service Learning in Occupational Therapy: Enhancing Potential in Context, which was due for publication in 2006. She asked whether I would like to write a chapter for this book titled, *Service Learning in A semi-Rural setting – assessing competence*. I agreed to this and some months later submitted a draft of the chapter, which included aspects of Khulu's story. She responded very positively but suggested that the contents of the chapter would be appropriate to two other chapters in the book and I was then asked if I would be prepared rather to use the initial chapter as input into two other chapters with other authors. These chapters are titled:

- *Towards understanding the history and context on practice and service learning.* Co-authored with Roshan Galvaan, Elelwani Ramugondo and Theresa Lorenzo.
- *Enhancing potential through diverse assessment approaches.* Co-authored with Madelein Duncan.

The book has subsequently been published, and I suggest that the fact that these chapters were accepted for inclusion in this book is indicative of the positive attitude of fellow academics towards the knowledge being generated by this research.

Meetings, workshops and conversations with colleagues

During the latter four years of involvement in this thesis, I took any available opportunity to meet and converse with occupational therapy colleagues. While the majority of these were fellow academics from most of the universities training occupational therapists in South Africa, a few colleagues from other countries such as Tanzania, Britain, Australia,

and Canada were also involved. All were therapists who had had substantial experience in the training of occupational therapists. These opportunities were used to share progress and obtain feedback and, in some instances, was a result of colleagues responding to some of the above-mentioned presentations that I had made at congresses. With the exception of two meetings which I attempted to tape over a tea party and lunch, with disastrous consequences (hardly anything was audible above the clatter of cutlery and chatter of voices), for the rest I either made brief notes during the conversations or otherwise held the key aspects of each within my memory until I could get home to jot them down.

The results of a workshop held in Durban with fellow academics and practitioners from public service hospitals for the purpose of identifying niche areas for occupational therapy in KwaZulu-Natal contributed to reinforcing the findings from the focus groups and resonance groups regarding areas of change in the profession, and assisted in refining the focus of this thesis (Appendix E).

Data analysis

As discussed under the section on data production and sources on pages 23 to 37 of this chapter, there were four sets of data: the fieldwork data, textwork data, statistical data and narrative data. The fieldwork and statistical data was mostly representative of the phenomenological phase of the research but was revisited for analysis using feminist and Foucauldian lenses during the microanalytical phase (see below). The textwork and narrative data was analysed specifically using the feminist, Foucault and critical theory lenses, and this occurred partly during the meso- and mostly during the macro-analytical phases. Data analysis can thus roughly be categorised into three phases:

Phase 1: Macroanalytic phase: this occurred in the initial phenomenological stages of the research and followed a broadly grounded theory approach. At this stage the route of the research was aimed at exploring whether or not the current curriculum in occupational therapy was adequately training occupational therapists to meet the needs of the changed health care system. The most significant data sets at this stage were the SAQA submissions, the Focus Groups, the Resonance groups and the statistics from the HPCSA. The theory that started emerging from the analysis of this data was that

there was a strong *medical model* bias in both the broad occupational therapy curriculum content and the discourse.

Phase 2: Mesoanalytic phase: Theory emerging from Phase 1 above redirected focus to historical documents to establish where the voice, power and representation of occupational therapy was situated in its early days of development. Using feminist, Foucault and critical theory lenses, emerging theory revealed a very strong patriarchal/medical model/political influence upon the episteme of occupational therapy, and serious concerns from people with disabilities about the efficacy of rehabilitation. Analytic emphasis was concentrated upon looking for links in historical sequences of events and structures and their outcomes in terms of their effects upon occupational therapy's epistemology, as well as causal events that could later be related to oppressive regime dominance. Analysis particularly explored how the data revealed factors that impacted upon the voice, power and representation of occupational therapists and people with disabilities in the early days of the profession's development.

Phase 3: Microanalytic phase: Theory emerging from the previous two phases suggested a much deeper and highly complex interplay of factors spawned from the particular historical and ideological context. It suggested a need to explore additional and more subtle and subversive factors that emanated both from the ideologies of the past and from the ways in which the victims (occupational therapists) had themselves become perpetrators and perpetuators of this ideology.

This required revisiting some of the original data sets and a much more focussed and in-depth analysis of selected chunks of these various data sets. Additional data in the form of the Life Stories of the two disabled men was also gathered for this purpose, and the historical documents on disability in the apartheid years were re-examined.

The analytic emphasis at this stage included the use of the feminist lens but it was at this point that Foucault's lens was used to explore new data and re-explore old data with particular focus on aspects such as:

- **Power over knowledge** - who gets what and how much; how power is exercised as a strategy; discourse within these power strategies; the articulation between scientific discourse and political power; levels across which power operate.

- Surveillance – how those in power create/d mechanisms for watching over those under their control, the controlled in this case being both occupational therapists and those they served i.e. ‘patients’.
- Confinement - how those in power put mechanisms in place to confine those under their control and more effectively exercise their power, and the operations put in place to organise the disciplines and institutions under their control so as to confine them.
- Genealogy and discourse - looking at concepts that emerge in the historical discourse under consideration in relation to the multiple influences by which they are affected. What is of importance here is not how the basic denotation of these d concepts and their terms arises, but they ways in which they have served as discursive tools reflecting, defining and determining power relations.

Analytical strategies used per data set

A brief description will be provided for each data set below, followed by a tabulated description summarising the analytical steps and approach used for the first two sets of data in Tables 3 and 4 on pages 49 and 57 respectively.

1. Fieldwork data

a) The SAQA submissions:

The eight occupational therapy training departments at universities in South Africa are: the Universities of Cape Town, Witwatersrand, Pretoria, Stellenbosch, Western Cape, Free State, Durban-Westville (since merged into the University of KwaZulu-Natal in 2004), and the Medical University of S.A (MEDUNSA, since merged with the University of Venda to become the University of Limpopo), all of which are hereafter referred to as the *training centres*. All eight training centres responded timeously in sending me their SAQA Submissions.

Data analysis: A qualitative approach using a combination of Huberman and Miles’⁵¹ and Strauss & Corbin’s⁵² approach to analysis of grounded theory was applied. The

⁵¹ Huberman, A.M. & Miles M.B. Data management and analysis methods. In Denzin, N.K, & Lincoln, Y.S. (1994). Handbook of qualitative research.

⁵² Strauss, A. & Corbin, J. (1998). **Basics of qualitative research: techniques and procedures for developing grounded theory.**

researcher was particularly concerned to retain the rich diversity of current practice espoused in the documents and thus the approach used was especially careful to overcome the risk of analysis becoming overly rigid. It is also significant to note here that terminology used within the final write-up of this aspect of the analysis was based upon typical terminology used within the various SAQA documents which later confirmed a strong adherence to the medical model ideological discourse.

It is possible that, in the attempt to reduce competency themes (outcomes) to a single coherent interpretation of the many ideas contributing towards them, it is possible that some aspects of these competencies may have been lost in the process. It is hoped errors or omissions of this sort were minimal, and that aspects lost in one category of competencies may emerge through the researcher's specific interpretation, offered.

Method: Please refer to Table 3 on page 49 below.

b) The Focus Groups

An extremely long and exhaustive process of analysis similar to that used in a) above was applied for the macro- and mesoanalytic phases. After the macroanalytic phase the data was packaged together with that of the SAQA submissions and was then sent out for feedback from the resonance groups, (see also Appendix H). Hereafter, during the microanalytic phase, the data was re-analysed, looking at it with more microscopic attention and specifically through feminist/critical theory and Foucauldian lenses, to explore aspects such as the signs of obedience to historically oppressive forces, racial discriminatory influences, discourse and language used and other *nuances* that reinforced the understanding of these effects upon the epistemology of occupational therapy in South Africa.

Method: Refer to Table 3 on page 49 below.

c) Resonance Groups

The absolute miracle of modern computer technology made it possible to download all 12 responses from their email attachments onto the significant sections of the two sets of analysed data (Annexure 1: SAQA profile and Annexure 2: Focus Groups) that had

been sent to each of the resonance group members for their feedback. It is important to briefly explain here the process used for preparing the data for analysis:

- Data returned by email from each respondent was cut and pasted directly from the various respondents emails onto the relevant sections of a pre-prepared document which had as headings all the questions originally asked of each respondent for each separate set of annexures (SAQA and Focus group – see appendix H).
- Different fonts and coloured highlighting were used to distinguish the 12 respondents' responses under each heading
- Where there were any areas requiring clarity I simply emailed back to the Group member and asked for this by highlighting the aspects concerned.

Method: Refer to Table 3 page 49 below.

TABLE 3: SUMMARY OF ANALYTICAL STEPS AND PROCESSES USED FOR SAQA SUBMISSIONS, FOCUS GROUPS RESONANCE GROUPS

ANALYTICAL STEPS ADAPTED FROM MILES & HUBERMAN	ANALYTICAL TOOLS ADAPTED FROM STRAUSS & CORBIN	SAQA Submissions	Focus Groups	Resonance Group
1) Noting broad patterns and themes through repetitive reading	1) Macro analysis: analysis through broad line by line reading of text	X	X	X
2) Seeing plausibility and making initial intuitive sense		X	X	X
3) Clustering by conceptual grouping – chunking.	2) Open Coding: Generating categories			
4) Looking for connections and where appropriate metaphors (Figurative grouping of data)		X	X	X
5) Making contrasts and comparisons to sharpen understanding by clustering and distinguishing observations.	Conceptualizing and naming various phenomena and concepts/ properties and dimensions	X	X	X
6) Differentiating themes and unbundling those that have been prematurely grouped and regrouping more appropriately	Abstracting	X	X	X
7) Shuffling back and forth between themes from different sets of data from same source e.g. SAQA submissions.	Naming categories and sub-categories	X	X	X
8) Factoring i.e. quantifying themes that are similar.	3) Axial Coding: develop and link categories and relate categories to sub-categories according to: - Causal conditions - Intervening conditions - Contextual conditions	X	X	X
9) Noting relations between themes		X	X	X
10) Finding intervening themes i.e. those that may have been hidden in the previous steps but which emerge towards end of analysis (bigger picture)		X	X	X
11) Making conceptual/ theoretical coherence through the various constructs in the literature reviewed and the theoretical frameworks applied.	4) Selective Coding: integrating and refining categories into theory 5) Microanalysis of extracts of the text	X	X	X
12) Emerging theory	Dictates next set of data	Medical model discourse	Identity issues and medical model dis-course	Medical model influences
13) Deciding on next set of data required to determine...>	Please see tables/information on data analysis for next sets of data	Indicated return to historical roots		
14) Final theory:		Still emerging		

Note: the bi-directional horizontal and perpendicular arrows indicate an iterative process during which the data was returned to and reread using a different lens as well as a process of shuffling back and forth between data set

2) Textwork data

At this stage of data analysis the feminist, Foucault and critical theory lenses became operative: thus, although the analysis did not follow such a rigid process as was applied to the Fieldwork data above, documents were scrutinised with a particular alertness to the specific aspects that will be described below, and an iterative process involving shuffling across documents occurred, in order to discern discourse and power commonalities.

Historical and current relevant documents

Selected relevant sections or aspects were undertaken of these documents were read, the pages and their contents were marked with pen or highlighter, and notes were made in the margin or on pieces of paper which were then stapled to the appropriate section of the document. These were then used in the various sections of this thesis for comparative purposes to demonstrate differences in legislation, policy and attitudes towards health professionals, race groups and disabled people in the 'birth days' of occupational therapy in South Africa as opposed to today.

Particular note was also taken of:

- The gender, race and professional spread of members elected onto constituted committees and committees responsible for the compilation of policy and legislative documents or in control of executive functions.
- Discourse, firstly using a Foucauldian lens observing specifically how the history of thought was constructed, in particular, how discursive hierarchies were created, and the sovereignty of the subjects constructing the thoughts. Secondly, the groups/types of discourses of these sovereign forces and voices across the historical continuum of the developing years of occupational therapy to its current level of status in South Africa.
- The production of truth and knowledge and how the processes, procedures and apparatuses were applied in what Foucault calls the discursive regime of the modern era⁵³; how power was exercised, particularly regarding control over knowledge sources and ownership.

⁵³ Tamboukou, M. (2003) **Writing feminist genealogies**. Journal of Gender Studies. Volume 12(1) 5-19.

The analysis took the form of identifying unities within the *common objects* of analysis e.g. Old (apartheid-era) South African Medical and Dental Council Rules and Regulations for Occupational Therapy; the *mode of statement* within each compared with other documents e.g. how these objects demonstrated control, paternalism, racism and hegemony; how *systems of permanent and coherent concepts* which make a unique language are deployed e.g. rules and regulations, constitution of various committees. Evidence of, *and identity and persistence of theoretical themes*, may account for unity but demonstrate rather the presence of systematic dispersion of elements e.g. themes of superiority of whites, doctors, males and male-generated knowledge.

Particular note was taken of the mutations and transformations of discourse over the period from apartheid era to the current democratic era^{54/55} and of how boundaries were altered, changing the status of occupational therapists from subservient, to masters of their own knowledge.

Please refer to Table 4 on page 57, which tabulates the process and steps of data analysis for the first three sets of data as set out in Table 1.

a) Joan Davy's historical review of the first 50 years of the SAAOT

This review became one of the most important historical data documents for this thesis, as it is one of the only existing records of the history of the profession, carefully documented by an occupational therapist, during the progress of that history since the inception of the first professional occupational therapy association and the first training of occupational therapists.

An initial approach using a combination of Huberman and Miles⁵⁶ and Strauss & Corbin's⁵⁷ approach to analysis was used, see table 4 page 56. Initial reading of Davy's document started to reveal recurrent and crucial historical incidents and influences: for example, the Eurocentric bias, the sovereignty, patriarchy and hegemony of the medical doctors' in terms of what knowledge was allowed or not allowed to be used by occupational therapists at the time, and who had spearheaded the training of

⁵⁴ Smart, B. Major themes and issues. In: Smart, B. Editor. (2004).

⁵⁵ McHoul, A. & Grace, W. Discourse. In: McHoul, A. & Grace, W. (Editors). (2000).

⁵⁶ Huberman, A.M. & Miles M.B. Data management and analysis methods. In Denzin, N.K, & Lincoln, Y.S. (1994).

⁵⁷ Strauss, A. & Corbin, J. (1998). **Basics of qualitative research: techniques and procedures for developing grounded theory.**

occupational therapists in South Africa. The nature of government control over the registration and recognition of occupational therapy as a profession in its own right was also revealed in the document. Further, the information in Davy's document was closely compared with that in articles on the history of occupational therapy in South Africa, especially those of Professor Tobias⁵⁸ and Professor Dart⁵⁹.

Once recurrent and key historical incidents and influences had been identified, these were tabulated as a colour-coded chronology of historical incidents such as control and leadership of SAAOT, control by Medical and Dental Council, and commencement of OT training, according to historically white and historically black universities⁶⁰. Four main categories of relevance emerged:

- Control and power relations within the Association during the 55 years under study
- Influences which impacted upon the epistemology and ontology of the profession's development over this period
- The sequence of the establishment of occupational therapy training courses at the various South African Universities in which training is currently situated
- Issues related to the identity of the profession

Identification of these themes thus contributed towards answering the following critical questions:

- ❗ *What is the changing nature of the role and scope of practice of occupational therapy both nationally and globally?* Here, the analysis provided a comparative

⁵⁸ Tobias Professor P.V. and

⁵⁹ Dart, Professor Raymond: were both instrumental in promoting Occupational Therapy in South Africa. Dart as the 'father' of occupational therapy in South Africa and Tobias as the first anatomist who lectured to the first occupational therapy diplomats from the University of Witwatersrand. I considered that these two gentlemen probably have/had the greatest insight, of all doctors, into its early roots in this country. Besides being anatomists both men are also renowned palaeontologists.

⁶⁰ Historically White Universities (HWU's) were those universities that had been established in the early colonial days and apartheid era, to provide tertiary education for exclusively white students. These were the Universities of Cape Town, Orange Free State, Pretoria and Witwatersrand. Later, when the apartheid government was under pressure from the rest of the world some token places were given to people of Coloured, Indian and Black races. Historically Black Universities (HBU's) were those that were created by the apartheid government to segregate and accommodate the tertiary education of races other than white. These institutions were created to further segregate the so called non-white groups i.e. MEDUNSA for blacks, University of Western Cape for coloureds and University of Durban-Westville for Indians.

platform against which to measure the 'then and now' controlling influences over the profession.

- ! *How has the history of development of the knowledge systems of occupational therapy within the South African context affected this changing role and scope?*

The themes and information that emerged from the analysis of this document clearly revealed the flaws within the epistemology of the profession and, because of this, provided indicators and thus partial answers as to:

- ✓ *How the epistemology of occupational therapy can be adapted to reflect a more appropriate South African identity;*
- ✓ *How the South African occupational therapy curriculum can be adjusted to produce graduates that reflect and practise this identity.*

In addition, a linear perspective of the chronology of certain power elements within the history of the Association was then plotted (for example control of presidency of SAAOT, control over registration, control over establishment of training centres, control within provinces/regions). Colour coding was used to distinguish each sub-category, and these were plotted according to aspects such as the period and/or duration, and/or sequence of their existence. A chronological representation of these linear perspectives can be found in Chapter 4 on page 85 in Table 5.

b) Various journal articles and book chapters

Relevant chapters and sections of these were read using an iterative process with a particular sensitivity and responsiveness to similarities and differences revealed in the analysis of Davy's document. These were then linked across different texts where patterns of similarities and differences were identified.

c) Various relevant government documents from the apartheid era

These included the old South African Medical and Dental Council's rules and regulations for health professions other than, and including, the medical professions i.e. South African Medical & Dental Council (SAMDC): Medical, Dental and Supplementary Health Professions Act, 1974 (Act 56 of 1974) (As amended) – Statutes of the Republic of South Africa – Medicine, Dentistry and Pharmacy and the Regulations Relating to the Constitution, Functions, Powers and Duties of the Professional Board for Occupational

Therapy (1976). These documents were analysed according to the description given at the commencement of this section on pages 50 to 51 above.

Volumes on Disability in the Republic of South Africa:

These documents were similarly analysed to the above sets of documents but, for clarification purposes, a specific description of sampling of sections of data from them is required. There were four main areas of *disabled care* identified within these documents which required the appointment of working groups to investigate them, i.e. Prevention, Treatment, Development and Care. For the purposes of this research, I randomly selected two of these volumes, viz. Prevention and Treatment, to use as examples of documentary data demonstrating the approach and attitudes towards people with disabilities in that period of history.

These volumes contained introductions and editorials that listed the names and titles of the various members on the Working Groups for Prevention and Treatment (see Appendix G). This provided an insight not only into the aims, ethical point of departure and functioning of each committee and group, but also into the constitution of its members in terms of race, gender and status (disabled or not), and their government or private sector affiliation. The title of each person on the committee was provided e.g. Prof. Dr, Mr, and Ms etc. These and the surnames were used to determine gender and race. It is quite easy to determine race in South Africa because Indian and African surnames are, with few exceptions, distinctive and easily identifiable.

There were some difficulties in determining members of the so-called coloured race as they mostly have surnames similar to those of any of the three categories of white, Indian or African depending on the parentage. However, given the historical location of these documents and the fact that it was a time when there was a tricameral Government with a House of Assembly for Whites, a House of Representatives for Coloured People, and a House of Delegates for Indian people, it was reasonably logical to assume that the committee members representing these respective Houses were of the particular race group identified with the particular House they were attached to. People with disabilities were identified according to the particular organisation they represented and also on the basis of my own personal acquaintance with various

disabled activists of the time who were listed on the committee, for example Kathy Jagoe and Mike du Toit⁶¹.

Given these explanations, it is possible that the analysis of these committees and groups as listed in Tables 7 and 8 in Chapter 6 (pages 143 and 144) could be slightly inaccurate in terms of race group representation, gender and disabled representation. For example, it is possible but unlikely, given the historical location of the documents, that some of the doctors and professors listed were women, I have assumed that they were all men as men dominated the medical profession, government and academia in those days. Thus, my analysis of gender has been based on this fact and whether a member's title was Mr, Miss or Mrs. It is also possible that some of the people representing disabled groups were themselves not disabled, as was also common in those days. There could have been one or two more Coloured representatives, but this is also unlikely, given the historical location. Thus, it is suggested that the demographic analysis provided in Tables 5 and 6 in Chapter 7 is a reasonably accurate reflection of the constitution of these two working groups.

d) Current relevant post-apartheid documents

Relevant sections of these were iteratively read and compared against the apartheid era documents with particular focus on comparison of the constitution of committees compiling the documents and the discursive content and styles within them.

e) Documents on standards and assessment criteria for the training of occupational therapists

A content analysis was done to compare the summary of the SAQA submissions and discourse used to that of the most recent draft of the HPCSA (SGB) guidelines for occupational therapy training and WFOT minimum standards of training (2006 and 2002 respectively).

⁶¹ During the late 1970's and early 1980's Kathy Jagoe and Mike du Toit, both people with disabilities, were deeply involved in the emerging activist movement for disabled people which later became known as Disabled People South Africa (DPSA).

TABLE 4: SUMMARY OF ANALYTICAL STEPS AND PROCESS USED FOR HISTORICAL DOCUMENTS.

ANALYTICAL STEPS ADAPTED FROM MILES & HUBERMAN	ANALYTICAL TOOLS ADAPTED FROM STRAUSS & CORBIN	Joan Davy's History of OT and early journal articles	Old SAMDC regulations	Various volumes of "Disability in RSA" apartheid era.
1.) Noting broad patterns and themes through repetitive reading	1) Macro analysis: analysis through broad line by line reading of text	X	X	X
2.) Seeing plausibility and making initial intuitive sense		X	X	X
3.) Clustering by conceptual grouping – chunking.	2) Open Coding: Generating categories Conceptualizing and naming various phenomena and concepts/ properties and dimensions Abstracting Naming categories and sub-categories 3) Axial Coding: develop and link categories and relate categories to sub-categories according to: - Causal conditions - Intervening conditions - Contextual conditions			
4.) Looking for connections and where appropriate metaphors (figurative grouping of data)		X		
5.) Making contrasts and comparisons to sharpen understanding by clustering and distinguishing observations.		X	X compare with post-apartheid documents	X compare with post-apartheid documents
6) Differentiating themes and unbundling those that have been prematurely grouped and regrouping more appropriately		X		
7) Shuffling back and forth between themes from different sets of data from same source e.g. SAQA submissions.		X	X	X
8.) Factoring i.e. quantifying themes that are similar.		X	X	X
9) Noting relations between themes		X	X	X
10) Finding intervening themes i.e. those that may have been hidden in the previous steps but which emerge towards end of analysis (bigger picture)		X		
11.) Making conceptual/ theoretical coherence through the various constructs in the literature reviewed and the theoretical frameworks applied.	4) Selective Coding: integrating and refining categories into theory 5) Microanalysis of extracts of the text	X	X	X
12.) Emerging theory	Dictates next set of data	Paternalistic / medical model influences upon development of epistemology	Oppressive/ racialistic and marginalizing influence upon development of OT.	Oppressive/ racialistic and marginalizing influence upon voice of people with disabilities
13.) Deciding on next set of data required to determine...>	Please see tables/information on data analysis for next sets of data			
14.) Final theory:				

Note: the bi-directional horizontal and perpendicular arrows indicate an iterative process during which the data was returned to and reread using a different lens as well as a process of shuffling back and forth between data sets.

3. Statistical data

The statistics received from the HPCSA on October 2004 registrations of occupational therapists were analysed using simple frequency checks to establish the race and gender profile. It was necessary to verify certain information with the statistics section of the HPCSA to obtain clarity on some of the terms used, e.g. “*unknown others*”.

4. Narrative data

These two life stories of Khulu and Sam were analysed as follows:

With Khulu's story I used what I refer to as a speculative analysis⁶², following the steps the steps outlined below.

- I considered his existing lifestyle and quality of life against the severity of his disabilities.
- I compared this speculatively against that of similarly disabled people who had had rehabilitation in the apartheid era. In other words, where would similarly disabled people who had been rehabilitated in the apartheid era stand on a continuum of poor to excellent quality of life and independence?
- I then speculated, based on my own experiences and training from that era, as to what rehabilitation Khulu most likely would have received had he been able to access it fully.
- I attempted to conjecture how this would have impacted upon his current status.

Khulu's life, as it was revealed to me during our interview and the circumstances leading up to and after the interview, was recorded in the form of a narrative. The story then becomes self-revealing and is also created through a process of *manifest interlinking*⁶³ of my own interpretations of his life through my physical experience of getting to and from his home, seeing and being in his home, actually seeing him manipulate himself up the mountain on a skateboard and then listening to his own portrayal of his life through the words of the interpreter. Khulu's story, and the *speculative analysis* of it are explored in Chapter 6.

⁶² This is another term coined to describe how data is used to speculate a “what if” outcome given the existing circumstances and speculation upon imposed circumstances.

⁶³ For this I have coined the term *manifest interlinking* to describe a method of linking related or conflicting thoughts and perceptions of the subject, from various temporally separate parts of the same dialogue, in order to reveal what becomes obvious.

Speculative analysis is a type of “what if” analysis in which one projects back into the past and speculates on the consequences/outcomes of an occurrence or particular type of intervention upon that particular individual at that particular stage in his/her history. In this case speculating centred upon the possible outcomes if Khulu had had rehabilitation in his early childhood years. The validity of this speculative analysis depends on the researcher having a sound knowledge of the expectations/criteria for outcomes during the particular era.

With Sam's story, which he had copied onto a high-density diskette for me, I was able to use a similar method to that used with the resonance groups, in that I could cut and paste Sam's responses to the various questions and also move bits of text around and link similar texts to make his story more powerful. Initially, a narrative analysis was done and core thematic concerns or reinforcing statements that he made were linked together to form a chunk of information revealing his feelings or experiences about a particular theme or topic, for example, the importance of his inter-relationships with others, or his own attitude towards his impairments and disability. The core questions that I had asked him to answer in his essay were used as the initial framework for narrative analysis.

In this analysis I have tried to illustrate and capture the young man, Sam, who has a very severe physical and communication impairment, and how this condition has impacted on, and continues to shape, his life, especially his relationships with others. Too much in-depth microanalysis would, in my view, have destroyed the richness of his voice and the messages he so powerfully communicates. I have thus tried to avoid word-for-word analysis but rather joined together aspects of the text (manifest interlinking) to reveal his voice⁶⁴. Sam is particularly articulate in English but frequently uses a phonetic type of

⁶⁴ For this I have coined the term *manifest interlinking* to describe a method of linking related or conflicting thoughts and perceptions of the subject, from various temporally separate parts of the same dialogue, in order to reveal what becomes obvious.

spelling, so that actually becomes “ashley”, much becomes “mush”, cheaper becomes “chipper”, beats becomes “bits” and so on. I have quoted him verbatim, although I have extracted and moved about relevant sections from the various answers to my questions and tried to weave them into a coherent set of thoughts and views that reveal the remarkable man that he is. The discussion of this analysis can be found in chapter 9.

Findings and discussion of data

The findings, interpretations and discussion resulting from the analysis of this data have been threaded or woven into the remaining chapters at strategic places to illuminate and/or illustrate specific critical points or to support specific arguments. They thus become an integral part of most of the chapters and as such cannot be segregated into one or two chapters. They represent the multiple actions, incidents and voices that have impacted upon and paved the way for the development of the profession of occupational therapy in South Africa as experienced, heard and seen through the mind, ears and eyes, and expressed through the voice of one who is simultaneously spectator, audience and actor.

Chapters 4 to 9 will explore and discuss the findings of the first sets of data and reveal their link to the 3 parts of this thesis. Chapter 3 will situate me as researcher within the context of this particular research.

CHAPTER THREE

(Un)packing the Baggage: a Genealogical Journey - situating/positioning the Researcher within the Context

Route map: This Chapter will describe the origins and background of the researcher, partially as extracted from books, documents and photographs but also as extracted from her own memory of relevant life events. Its purpose is to position her within the South African context and allow those evaluating the research to gain an insight into, and appreciation of, those historical factors that may have influenced her as researcher and autoethnographer. It is also intended to demonstrate how the researcher forms an integral part of the development of occupational therapy within South Africa and, as such, is situated within both the solutions and the problems of its development.

Vignette #1:

"I have been putting it off. I close my eyes to the outside world in order to see the rhythms and shapes. Will it help not to tell stories? Will I understand this land any better? But it is unfair. It is not right to bring people to look and to look, and then expect them to continue living as if they haven't seen. People turn their glazed eyes to me. Who made the bed in which we now all must lie down?" (Breyten Breytenbach 1998)¹

ORIGINS

I write this as it comes to mind and leave it to you, the reader, to deconstruct the different layers of meaning and interpretation within it. On reflection upon it, I am reminded of a glacier, enormous and apparently immovable but which keeps moving at an imperceptible pace, so slow that those ice and dirt particles within it, which form part of it, although unaware of its movement, become a collective within that power and movement and whatever is crushed along the way is really of insignificance at the time.

Colonialism

Depending on which side of the fence one sits, colonialism is perceived and portrayed either as the demon which is held responsible for all the woes that have befallen previously colonised countries and continents, or it is perceived and portrayed as the redeeming force responsible for bringing "civilisation" and "light" to "dark continents".

Van Staden (1998)² maintains that the philosophy of Western imperialism and the colonial strategies of government depicted what he calls "*the dark world other: 20*" as the savage opposite of the civilised Western citizen. In this way colonialism both homogenised the 'other' and simultaneously separated the 'other' into distinct groups, tribes or categories from the coloniser. Senghor (1998)³ reveals the irony of this situation when referring to British colonisation. He maintains that the British have been criticised in the past for not having a sense of universality, for their refusal to assimilate native populations. Today, they are praised for having emphasised points of difference rather

¹ Breytenbach, Breyten. (1997). **Dog heart chapter: A travel memoir**. Human and Rousseau. Cape Town.

² Van Staden, C. Using culture in African contexts. In: Coetzee, P. & Roux, A. (Editors) (1998).

³ Senghor, Leopold. S. Negritude and African socialism. A reading in: Coetzee, P. & Roux, A. (Editors). (1998).

than similarity. Magubane (2000)⁴ maintains that behind the facades built by colonialism are empty forms that stifle and destroy the forces of life instead of serving them, and that those wanting to know what happened during the colonial era find themselves “trapped behind the trivia of apologetics.”

Algado and Cardoso (2004)⁵ maintain that in order to avoid a repetition of the mistakes introduced into health care by colonialism, occupational therapists in post-colonial countries need to become more aware that the situated meaning of culture in their practice is an essential core concept.

Letter # 1: A Personal Exposure

In order to be transparent and position myself within the context and route of my journey, it is essential to present a picture of my own background because then I am firmly establishing myself as part of the problems and solutions which have given rise to this thesis. This personal exposé has necessitated having to probingly reflect upon my own history, ancestry and its colonial roots, as well as the history of my profession in South Africa and my part in it. It is thus important to make it clear from the start that this personal historical reflection should not be seen as an apology but rather as a requiem to a past which has had a profound influence upon my life's journey and all the conflicts and contradictions it has given rise to throughout that journey.

Inextricably interwoven within the histories of both my paternal and maternal ancestors there are continuous patterns and threads of colonialism. The following descriptions are based upon recollections from tales told me by my mother and father, back-ups from siblings, a copy of Bryer and Theron's “The Huguenot Heritage: the story of the Huguenots at the Cape”(1988)⁶ inherited from my father and in which he has highlighted relevant sections on our ancestors in pink, and a photocopied handwritten document of the paternal family tree, written in a very neat and careful hand by one “Tante Anna”. My mother's ancestry is based upon her own manuscript written for a granddaughter's school assignment on a portrait of her grandmother and a photocopy of this assignment by Victoria Cullen in 1992 titled “The life of Diana Joubert”⁷. In addition I also have in my possession old photograph albums that belonged to my mother and my maternal grandfather.

The Paternal side:

The first ancestor to colonise Africa was a French Huguenot called Pierre Joubert (Jaubert) originally of La Motte-d'Aigues in Provence. The term Huguenot was derived from the German word “eidgenosz” which meant “oath-comrade” and was a term used to describe Protestants of Calvinistic origin who had broken away from the oppressive forces of Catholicism in France in the 16th Century.

⁴ Magubane, B.M. (2000). **African sociology – Towards a critical perspective: The collected essays of Bernard Makhosezwe Magubane.** Africa World Press. Eritrea.

⁵ Algado, S. & Cardona, C. The Return of the Corn men. An intervention project with a Mayan community of Guatemalan retornos. In: Kronenberg, F. Algado, S. & Pollard, N. (Editors). (2005).

⁶ Bryer, L. & Theron, F. (1988). **The Huguenot heritage: The story of the Huguenots of the Cape.** Chameleon Press. Diep River, Cape.

⁷ Cullen, V. (circa 1992). The life of Diana Joubert. As part of a school assignment in Grade 10, my niece Victoria Cullen was required to write the life story of her grandmother which she based upon an interview with her grandmother and a hand-written outline of key elements of her life, written by her grandmother (my mother), copies of both of which are in possession of the researcher. See also under references: Joubert, Diana. (Circa 1992).

During this period of a hundred odd years, there was considerable religious revolution in France resulting in the massacre of approximately 20,000 Huguenots. Finally, in 1685 when the Edict of Nantes, which had allowed some measure of protection for the Huguenots, was formally revoked, Protestantism was declared a “false religion” and the practise thereof was totally outlawed.

In spite of the fact that emigration of Protestants was punishable by confiscation of property and banishment to exhausting labour on the French galleys that were plying the Mediterranean at the time, an organisation of illegal escape routes was set up and it is estimated that approximately 200,000 Huguenot refugees succeeded in leaving France between 1681 and 1721.

At the time the Dutch East India Company was in need of “free colonisers” or “vrye burghers” at the Cape of Good Hope in order to establish farms to supply the many vessels that used this point as a stopover on their way to the lucrative spice trade of the East. It was to this somewhat challenging future and escape from their particular oppression that my forefather Pierre and many other Huguenots turned ⁸.

At the age of 24 years Pierre Joubert married Susanne Reyne, shortly before their departure from Rotterdam Harbour to the Cape of Good Hope in the 160-foot sailing vessel the “Berg China”. Departing on the 28 March 1688 the voyage took nearly 5 months and was extremely hazardous, with water and food shortages, rough seas and epidemics of illness throughout. It is thus not surprising that many people died on these voyages and Susanne Joubert was one of those who did. It seems that Pierre did not take long to overcome his grief: before landing in the Cape of Good Hope he had remarried one Isabeau Richard, herself a passenger and widowed on the same voyage. The Berg China arrived in Table Bay on 4 August 1688 and Pierre was given a sum of 28 pounds and two shillings from the Batavian society to assist him in starting his new life. He seems to have prospered and eventually owned the farms La Motte, La Provence, La Roche and Le Plaisant where he raised his family of ten children. Some of these farms still exist as excellent wine farms today⁹.

According to Bryer and Theron (1988)¹⁰ there is evidence to suggest that there was dissatisfaction amongst the Huguenots because the Dutch were perceived as being more privileged and suppressing the French settlers by imposing their culture, language and religious convictions upon them. This, according to my father, finally led to the demise of the French language in the Cape. It appears that the Huguenots were also clannish and sectarian, adding to the existing barriers that militated against the rapid integration of the European colonisers of the Cape of Good Hope.

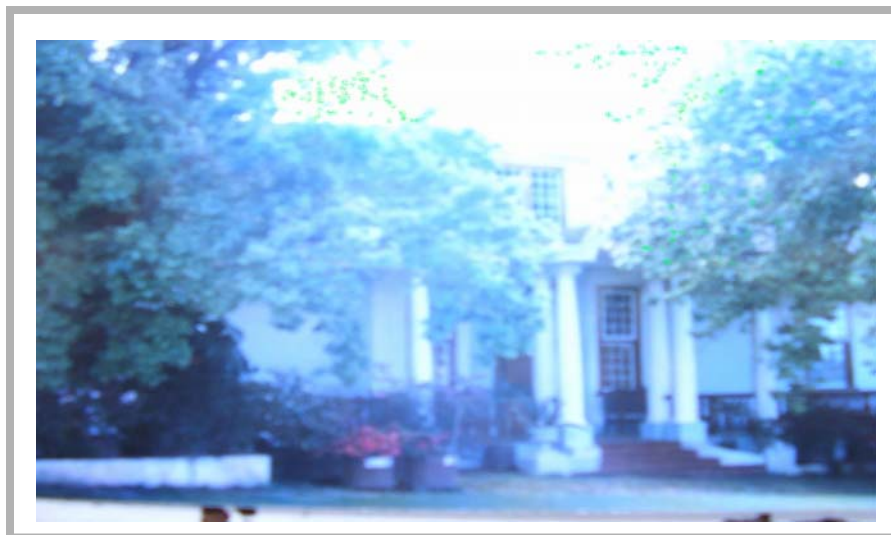
Initially the Huguenot settlers were too poor to employ slaves. However, a decade after their arrival many had prospered enough to employ them and I quote a visitor to the region in 1689, one Legat, who said “Our refugees make the Hottentots (Khoi) work in their harvests, vintages, and whatever else they please, for a little bread and tobacco” (p45). The Huguenots were also largely responsible for bringing the knowledge and skills of vine cultivation and wine making to South Africa and today the farms of La Motte and La Provence in the Cape produce some very fine export wines.

⁸ Bryer & Theron (1988)

⁹ Ibid

¹⁰ Ibid

My Paternal Grandfather, Schalk Willem Joubert, was an eighth generation settler. He came from a family of 12 siblings, all of whom lived on the family farm of Twyfeling in the district of Wellington in the Cape.



Ouma's wing at Twyfeling (Great grandmother), Wellington, Western Cape Photo: Leo Joubert

Schalk studied medicine at Edinburgh University where he met my maternal grandmother, a Scottish lady named Kathleen Fisher. He brought her back to South Africa where he opened a practice, first in Kroonstad in the Orange Free State, later moving to Harrismith. As one of the few doctors in the area he had to travel long distances to get to see some of his patients, so he decided that flying to outlying areas would be much easier for him, and for this purpose he bought himself a bi-wing aeroplane. It was during the process of learning to fly this plane that he was killed together with his pilot-trainer in a crash in Harrismith at the age of 47 years.

When Grandpa died, Grandma Taffy (as she was known) took my father and his sister, Eileen, back to England where my father was enrolled at Westminster School and later graduated as a medical doctor from Oxford University. In 1939 he met and married my mother shortly after graduating, and she bore him his first three children in England during the Second World War. He was away in the Navy most of this time and I recall her stories of how, when the air raid sirens went off, she would have to carry all three children down to their shelter under the staircase and read them stories (Rudyard Kipling, Beatrix Potter and AA Milne) by candlelight until all was clear. She also described the food rationing at this time in which "small amounts of butter, marge, cheese and sugar were doled out once a week and 9 pence worth of meat per person per week"¹¹.

After the war, Leo's childhood memories and a deep love for Africa must have got the better of him and he returned with my mother, Diana, and their three children to finally settle back in South Africa. They sailed from England on the Carnarvon Castle and arrived in Cape Town on 2nd August 1946. In his urgency to acquaint his family with the uniqueness of Africa Leo kitted out himself and all three

¹¹ Joubert, Diana (circa 1992). Notes written by hand for her granddaughter Victoria's School essay on the life of her grandmother. Personal Property of RWE Joubert.

children (including my two sisters) in ḳhiaḳi shirts and shorts, he bought an old second-hand Packard car, bundled his family into it and drove them over the dusty dirt roads of that time, all the way to what was then known as Southern Rhodesia. My mother described the “joys” of this trip which entailed, at the end of every exhausting dust-filled day of travelling over potholed roads, having to wash out 4 sets of ḳhiaḳi outfits and her own dress because they were so dirty.

They settled on a farm in Rivonia and my father's first job was at the Johannesburg General Hospital. Shortly after commencing there, he was offered a job in Swaziland, then a British Protectorate, and they moved there in 1947. My brother Charlie was born a few months after arrival and 17 months later, on the 25th of September 1948, after an apparently long and difficult labour, in the single maternity ward set aside for “whites” at the Mbabane hospital, I breathed air for the first time. I will return to Swaziland later, but for the present I continue with an outline of my maternal ancestry.

Maternal ancestry:

Besides some old, rather moth eaten, photo albums filled with sepia photographs of people in bonnets and bows, military uniforms, some on elephants and polo ponies, in jungles or leaning on dead tigers, I don't have much history of my maternal grandparent's origins. My maternal great grandfather Pyet was French, my grandmother was English and my maternal grandfather was a Scot. My mother was born on 7th April 1919 shortly after the armistice of the First World War. When she was 9 weeks old my grandparents took her with them by boat to India where my grandfather had been asked to manage a large tea estate in Bengal.

At the age of four my mother was sent back to England to attend boarding school and stayed with an aunt during holidays. This was because “it was not healthy or practical to bring up a child in India and there were no schools there” (Cullen 1992). One wonders where all the Indian children went to school? I reflect now with a deep sense of concern about that vulnerable little girl of four, who was to become my mother, scarcely able to dress and feed herself independently, parted by thousands of miles of sea and jungle from her parents and boarding in what was then the cold, rigid British boarding establishment. Holidays with a loving aunt, uncle and two cousins made this more bearable.

At the age of six my mother became very ill with measles and on doctor's orders was given a year to recuperate, so she travelled weeks by boat to India where she spent a year on the tea plantation in Bengal. Later my grandparents moved to Assam and, when my mother was a teenager, she went out for extended holidays to join them. I recall her marvellous storybook tales of rides on elephants through the jungle, brown bears stealing food in the kitchen at night and a courageous tea picker, whose baby was about to be stolen by a leopard, strangling the creature to death and being, herself, ripped to tatters by its claws in the process.

But something about this life troubled her because I remember her recalling several times as an old lady: “You know, Robin, I look back with shame now when I think of how we lived in those days”. They would apparently go to “the club” on a Saturday where Grandfather played polo most of the day and Grandmother played bridge with other wives. Afterwards it was the usual gin-and-tonic routine and then a fairly long trip back through the jungle to their home. In spite of the fact that they would sometimes only get back by eleven o'clock at night there was always a house full of white uniformed and turbaned servants awaiting them with a three-course meal. They were waited upon while the meal was leisurely consumed. One of the categories of servants, the paaniwalas, had the job of repeatedly pulling the string of the large fans that kept them cool in the tropical jungle's heat.

Today, as an avid conservationist, I look with a deep sadness at a sepia picture of my grandfather supporting the dead-eyed head of his hunting trophy, a Bengal tiger, while its slack, lifeless and magnificent gold and brown striped corpse lies stretched out on the grass next to him. I wonder now how many grandfathers like mine have, together with those responsible for deforestation of jungles, contributed to the current rapidly declining numbers of these tigers.



Maternal grandfather with his "trophy", Bengal, India.

Photographer: Unknown

My own life:

I was born on the 25th September 1948 in Mbabane, Swaziland, the youngest of 5 siblings. Coincidentally this was the same year that the National Party came into power in South Africa¹². I recall those days of my childhood and early teenage years with a deep and painfully pleasant sense of thrill and nostalgia. There was a peace and freedom then that has been unsurpassed in any other stage of my life. From what I can remember there was a cordial, respectful and trusting relationship between the colonisers and Swazi people. Our family went on frequent holidays up to exotic locations along the Mozambique coast leaving our home unlocked for two or three weeks at a time without a single burglary. As children, during our school holidays, we either took part in gymkhanas or would saddle up our ponies, shrug on a satchel full of sandwiches and fruit juice, meet with similarly mounted friends and ride for miles into the mountains in search of rock pools, waterfalls, and caves. Except for giving our parents an indication of which hills or direction we would be taking, the rest was left to us.

¹² The political party formed by Barry Hertzog in 1914 to represent Afrikaner interests. Fused with Jan Smuts and the South African Party in 1934 to form the United Party and emerged as the Herstigte Nasionale Party after Hertzog and Smuts split over whether to enter the war against Germany. It then linked with D.F. Malan's 'purified' Nationalists and finally came into power in 1948 renamed as the National Party: (Saunders 1988:519). It was this party under the leadership of H.F. Verwoerd that architected apartheid.

We had “servants” and the gardener was referred to as the “garden boy” and the Swazi people were referred to as “natives”. All the “servants” that ever worked for us had Christian names with mostly biblical origins such as Ruth, Miriam, Shadrack, Abednigo and a December who was our gardener for many years. They were fed and accommodated and paid a salary of a few pounds a month. We had a few young Swazi friends whom we played with as children but it is significant that I cannot recall their names. Mostly it was a “we” and “they” relationship. During these years I recall a few occasions at lunchtime when my father would sit pale-faced and fiddling with his food. Once I asked him what was wrong and he replied that he had spent the morning witnessing the execution by hanging of prisoners at the local prison and thereafter had had to certify all the victims as dead.

We were certainly very privileged but not spoilt. Our father was a man who believed his children should be tough, so although we had comfortable, well fed and well educated existences, he deliberately exposed us to hardships to “toughen us up”. He would, for example, not allow my mother to drive me and my brother Charlie to school, and we either walked the 5-odd kilometres to and from school each day or Charlie rode his cycle and I rode my horse with a pair of dungarees over my gymslip. There was a paddock at school where I left my horse for the day. As a young girl of 11 years old, on a Sunday I frequently set off at 5 am on horseback, leading my father’s two polo ponies approximately 27 kilometres to the polo field in the Ezuluwini valley¹³. After spending the day caring for and getting a refreshed pony ready for each chukka while he played on I would set off on the long trip home at about 4 pm often arriving close to 9 o’clock in the evening.

At the age of 15 I was sent to board at St John’s Diocesan College for Girls in Pietermaritzburg because the education at St Mark’s school in Mbabane was considered not good enough (deja vu?) It was in my latter years at this school that I learned, in a careers talk from one of our teachers, about occupational therapy. I decided immediately that this was a career that covered exactly the diversity of subjects within the sciences, arts and humanities that interested me, and because it focussed on the promotion of independence for people with disabilities through the use of occupation, it made great sense to me at that time and provided exactly what I sought in a vocation.

In 1964 my parents moved to Pietermaritzburg and I matriculated in 1968. Determined to be independent after this, I had been trying to obtain a bursary to pay for my enrolment as an occupational therapy student at what was then the Pretoria College of Occupational Therapy. I applied too late the first year and consequently had to spend a year waiting to reapply, so I decided to do a year of nursing as an appropriate experiential time-filler. I enrolled as student nurse at the hospital with the infamous name of H.F Verwoerd¹⁴ and learnt the basics of nursing for a year whilst also improving my conversational use of Afrikaans (I had obtained an E symbol for it in Matric!). Having secured a bursary through what was then the Natal Provincial Administration, which paid all my tuition fees and provided me with a small but adequate pocket-money package, I was finally accepted to do the three-year diploma at the Pretoria College of OT in 1969. Training was then

¹³ Ezuluwini is the Swazi word for heaven

¹⁴ H.F. Verwoerd is described by Saunders, (1988) as “the man who more than any other was to embody the Afrikaner dream of apartheid: 423”. He became Prime Minister of South Africa in 1958. In his relentless promotion of his separate ‘nations’ theory, he argued that contact between the different race groups in South Africa would hinder their evolution into ‘nationhood.’ (p423) Ironically, he was assassinated by a mentally disturbed white man, Dimitri Tsafendas, in the House of Assembly, in 1966. Many buildings, streets and monuments were erected in his name during the apartheid era. Most of these have been pulled down or changed today and replaced with the names of the heroes of the struggle against apartheid.

exclusively white and almost exclusively female with the exception of a couple of males. Most lectures were in Afrikaans by College staff and service courses such as Anatomy, Physiology and Psychology were given at sites on the campus of the University of Pretoria. It was a wonderful three years in which I was able to combine my interests and aptitudes of a love for the creative arts with those of the medical, scientific and psychological complexities of humankind. I had everything expected of a young white girl of my age at that time: a group of special friends, an old but reconditioned Volkswagen beetle, a reasonably handsome boyfriend who was studying to be a veterinary surgeon and a loving home to which I could retreat whenever necessary and enjoy the comforts and luxuries of the middle-class white South Africa of those days.

As young students we did often sit around our glasses of beer, mugs of old brown sherry or coffee and discuss some of the more disturbing issues of apartheid, but for the most part I found myself complacently and comfortably cushioned within a world that had been orchestrated to ensure my well-being and which deliberately screened me from the reality of the situation, so that it became very easy to ignore that reality. In the early 70's like a "luislang"¹⁵ digesting the enormous meal that grotesquely distorts its body, the disturbing reality of what was happening around me eventually penetrated my, until then, comfort-zoned world. It was particularly after I had qualified and witnessed the discriminatory practices within the Health Services of those days that this awareness of the deeper and more terrible truth of what I was part and in the midst of, hit the stomach-pit of my conscience.

When I started my first job at Addington Hospital in 1971 although it was regulation to do so, I refused to treat the white and coloured patients in separate rooms and at separate times. My boss at the time confronted me about this deliberate disobedience. I informed him that it was a breach of my ethical code and own conscience to abide by these rules and that if he felt so inclined he could have me fired for disobeying them. He never bothered me again. In the early 1980s I took part in a march to protest against the inequitable health services at the time. I recall an initial fear and later enjoyment when, together with a few thousand others, we toyi toyi'd¹⁶ down West Street to the City Hall of Durban to hand over a petition to the Director of Hospital Services. But these are simply baby fleas on the back of the elephant of activism against that system.

I suppose it was at around this time that the true stirrings of my rebellion against the system began, but it is difficult to pinpoint exactly when or where this occurred. It was a slow process that culminated when in 1981 I commenced working as Head of the Department of Occupational Therapy at the University of Durban-Westville where, for the first time in my life, I was able to work closely and in relatively normal partnership with people of other race groups and so really get to know them and the terrible insult and indignity that apartheid had caused them.

I have practised both as a therapist and as lecturer in occupational therapy for the past 33 years, for most of which I have been involved in both the setting up of new occupational therapy departments and training courses (at the Universities of Orange Free State and Durban-Westville) and then

¹⁵ "Luislang" is the Afrikaans word for a python and literally translated means "lazy snake". The python preys on smallish mammals such as rabbits and small antelope. It kills its prey by wrapping its coils around the animal and asphyxiating it, once dead it then swallows the prey whole. Depending on the size of the prey, it may take days for it to be digested and thus during this time the python stays inert rarely moving from one spot.

¹⁶ Toyi toyi refers to a lively and defiant dance in which the dancer bounces from one leg to the other usually in rhythm to a protest song or chant. It was used by protestors in the apartheid years whenever they went on any mass protest march.

teaching in them. I was also involved in the professional association of occupational therapists for many years in various capacities, including as vice president and then president for several years during the 80's and 90's. I have thus been exposed to several crucial aspects related to the politics and development of the profession of occupational therapy in this country, which I feel has privileged me with insights and experiences that have contributed to much of the thinking behind this thesis.

Postcard #2: Cadavers in Fancy Dress

I recall how, in my first year as a student occupational therapist, wet behind the ears and bubbling with naïve enthusiasm, how we were introduced to our cadavers for the first anatomy lesson. The dissecting hall was enormous, stretching from the front to the back wall along the whole of one side of the “BMW Gebou”¹⁷. It was clinical and sanitised from top to bottom, the air pungent with the smell of formaldehyde. What seemed like rows and rows of stainless steel “plinths” stretched out before us, and upon each lay the half distinct shape of a human body wrapped in neatly folded white plastic sheeting. We too were all neatly robed in our starched white laboratory coats with our little box of prodders and tweezers with which to prod and tweeze the various muscles, nerves, blood vessels and other bits of human tissue that our examinations would reveal to us. (We weren't allowed to dissect the corpses; this was done first by the medical students and as they dissected a segment, so we were allowed in after them to study what they had revealed, such as an arm or thorax or abdomen). I remember saying a little prayer asking God to help me to continuously respect the fact that I was dealing with a human body, albeit a dead one.

The moment of removal of that plastic sheet was one filled with a strange ambivalent suspense between absolute dread and a macabre curiosity. What was revealed was something of a cross between a horror movie and a comedy. The body had been so soaked in preservative that the skin had become thick, folded and shiny rather like the leather on a lounge suite. The neck and arms had already been dissected revealing what resembled the strips of biltong one sees hanging in the butchery shop, interspersed with a network of vessels and other viscera snaking in and out of the strips of biltong. The lips were tight and stretched inadequately over teeth that grimaced ghoulishly and the eyelids were pulled closed over the sunken, dead eyes, the phallus lay shrivelled and small. Most of the cadavers were male and, with the exception of one, all were African. A record containing each cadaver's biographical details and cause of death was pinned on the notice board at the entrance to the dissecting lab. Many were John Does¹⁸.

There were three or four of us assigned to a cadaver. It took about three sessions (of a few periods long) to become accustomed to our weekly encounters with our cadaver, to whom we had assigned a name but which, fortunately, I cannot recall today. One day after about the fourth or fifth session we pulled off the white plastic shroud to find him with a pair of sunglasses over his dead eyes, a peak cap on his head and a note rolled up to resemble a cigarette in his mouth. When we read the note it was from the medical students who had been dissecting him and was an invitation to a party that weekend ... I recall we all giggled... “Dear Lord, please help me never to lose respect for this body that once housed the spirit and life of John Doe.”

¹⁷ Basiese Mediese Wetenskaplike Gebou (Basic Medical Sciences Building) a large multi-storied building belonging to the University of Pretoria where most of the anatomy and physiology lectures for medical students and other health sciences professions were held in those days.

¹⁸ John Doe is the name given to “patients” or corpses that cannot be identified.

Having briefly positioned myself within this small fragment of South African history it is now time to explore more deeply the development of the profession of occupational therapy in South Africa and briefly also its development globally. Using some of the data described in Chapter 2 the following chapter will show how the profession was moulded by the many powers and forces active in this country at the time of its development, and will attempt to also show certain parallels between the development of occupational therapy in South Africa and its development in the rest of the world.

CHAPTER FOUR

The (Un)packing Continues: a Historical Journey into the Development of Occupational Therapy in South Africa

Route map: This chapter will explore the first 55 years of the history of occupational therapy in South Africa, looking through the lens particularly of an elderly occupational therapist historian who lived part of that history and through the lenses of some of the medical doctors who were instrumental in fathering the profession here. It will particularly look at the forces and tiers of power, both within and outside of the apartheid government, which controlled the profession at the time. It will also briefly review the development of occupational therapy in the United States and the United Kingdom to demonstrate similarities and differences in this development, and how South African occupational therapy was particularly manipulated and marginalised by the political forces at play in the early days of its development

SECTION 1:

A brief historical review of the first 55 years of the South African Association of Occupational Therapists (SAAOT)/Occupational Therapy Association of South Africa (OTASA)

Introduction

The following account is based upon the analysis of a document compiled by Mrs Joan Davy, honorary historian of SAAOT, in which she briefly documented the inauguration and subsequent year-by-year account of the history of the professional association of occupational therapists in South Africa from 1945 to 2000. This is by no means a complete historical review, and there are important aspects of the history of the Association that are excluded from it or incomplete.

To do justice to a more complete history would require in-depth perusal of the Association's archives of previous Council meetings, policies and Standing Committee documentation. However, Mrs Davy's historical chronological documentation of major events and articles written by "pioneer" doctors in the early years of this history, have proved adequate for the purpose of this thesis which explores the control of power within the Association from its inception, and highlights this and other factors which influenced the ethos, epistemology, ontology and consequent content of the South African Occupational Therapy curriculum.

In order to prevent confusion about the two names referred to in the title of this section of the chapter, it is important to provide some background before proceeding with the rest

of the analysis. At its birth in 1945 the professional association of occupational therapists was referred to as the South African Association of Occupational Therapists (SAAOT). However, during the course of its history, education and training was expanded to include other categories of auxiliary personnel referred to as Occupational Therapy Assistants who were also eligible to become members of the Association. The name of the Association at the time implied that membership was exclusively for occupational therapists.

In addition to this, by the early 1980s, and for the first time in our profession's history, more African occupational therapists were qualifying from the historically black universities and becoming eligible for membership of the Association. However, many of them associated the SAAOT with the *apparatchik* of apartheid; hence, some of these therapists avoided becoming members of SAAOT. Thus it was that after 1994 with the new democracy and its ongoing process of transformation, the constitution, structure and name was changed to Occupational Therapy Association of South Africa (OTASA) in 1995.

[As Vice President and later President of the SAAOT from 1984 to 1991 I participated in several meetings with black occupational therapists regarding their discontent with the Association at the time, this is not recorded in the documentation of events by Mrs Davy because she would not have been privy to that information.]

Control and Power relations within the association over a period of 55 years from its inception in 1945 to the year 2000

Pillay (2003)¹ refers to the allegiance or affiliation with male-centred ways of knowing, male epistemologies and male ideologies as a form of androcentrism. In discussing the history of Speech-Language therapy and audiology, which has many parallels with occupational therapy, he reveals the male-dominated influences on training in this field and speculates on whether women would have engendered a different kind of knowing and doing if they had conceived of the profession.

This section of the chapter reveals, amongst other controlling influences, the control wielded not only by the white, male doctors who established occupational therapy

¹ Pillay, M. (2003). **(Re)positioning the powerful expert and the sick person: The case of communication pathology**. Dissertation submitted in fulfilment of the requirement of the degree Doctorate of Education through the School of Educational Studies at the University of Durban-Westville. Durban.

training in the early 1940's, but also the control of various Government structures and regulatory bodies over the development of the profession of occupational therapy in South Africa, from its birth to early adulthood.

This information provides insight into how the epistemology of occupational therapy was dominated by a patriarchal, medical oriented and oppressive legislative influence and how these forces governed occupational therapy's early ways of knowing, which in turn inform the key questions 2 and 3 of this research viz.

- ❓ How has the history of development of the knowledge systems of occupational therapy within the South African context affected this changing role and scope?
- ❓ How can the epistemology of occupational therapy be adapted to reflect a more appropriate South African identity?

Four main categories of power emerged from the analysis of Davy's document. They were:

- The control of the presidency of SAAOT
- The control by the South African Medical and Dental Council over the content of the profession's curriculum
- Control by Government over the scope of practice of occupational therapists
- Regional Control over the SAAOT within the occupational therapy 'community'

Each of these categories will each be discussed below:

The control of the Presidency and chair (man)ship of SAAOT

For the first 22 years (1945 until 1967) after its inauguration, the position of President and Chairman of the SAAOT was filled by a person from a profession other than occupational therapy, with the exception of the first year i.e. 1945/1946, when the position of President was held first by a Mr H. Pentz (a member of the Transvaal Provincial Council), and later within the same period, by a Miss Iris Marwick (matron of Tara Hospital at the time).

Thereafter, for the entire period from 1946 until 1967, the post of President of the Association was filled by a medical doctor or a psychiatrist. And it appears from the

scant accounts available in Davy's document, that all major changes, legislation and policy introduced into the Association during this time were initiated by these presidents/chairmen. The following examples from Davy's text, will illustrate how these office-bearers wielded power and control.

Key to interpretation of the following analysis:

- Direct quotes from Davy's document are written in Bradley Hand ITC font.
- The researcher's comments on these are printed after each quote in a comment box or in brackets within Davy's text, using the Times New Roman font.

1947 “ Dr Davidson instituted major changes (1) in the constitution necessitated by the increasing number (2) of therapists (i.e. they had increased from 5 to 8 members!) and to give more flexibility in the administration”

Nothing more is said about why there was the need for more flexibility in the administration and it is hard to imagine why such major changes (1) to a constitution should have been necessary with such a small membership (2) of approximately 8 people at that time)

1948 “ under the direction of (1) Dr Moross general administrative procedures were greatly improved (2) and Council meetings were held every alternate month, an indication of the growing volume of work (3)).

These words (1) suggest the controlling power of the president coupled with the possible administrative inexperience, and dependency of this small group upon their (medical doctor) president at the time. This, together with the phrases (2) and (3) used to describe the level of improvement which the administration of the Association had attained in a mere 3 years, is somewhat hyperbolic, given the size of the membership.

1953 “Dr Allen (new president/ medical superintendent Baragwanath Hospital) and Dr Moross (outgoing president/medical superintendent Tara Hospital) drew up a memorandum on the formation of regional branches (1) (presumably this was the guiding policy document to establish some form of control at regional level, because by this stage there were several OT's now practising in the Cape) but response from members was so poor (2) that the matter was left in abeyance (3)).

It is difficult to know at this stage whether the OT's participated in (1) or not. It is possible that the poor response of members (2) and (3) could have been a sign of the beginning of what appears to have been some discontent about the fact that the administrative power of the Association was situated in the then Transvaal and members from other regions possibly felt excluded. (This aspect of the control and power relations within the Association will be discussed later.)

1956 A symposium was organised and held in Johannesburg with the title "What to expect (1) from the Occupational Therapist". Speakers were from the medical profession (2) and from the Association. (3)

In spite of the fact that occupational therapists participated (3), organised and presented at this symposium, the fact that members of the medical profession (2) were called in to represent what was to be expected of occupational therapists (1) at that stage, is indicative of where the seat of the knowledge base lay and thus the dependency of the therapists at the time on the medical profession to represent them. It also alludes to their lack of certainty about their identity. The implication here is that medical doctors influenced the epistemology of the profession in this country at the time and shows how the identity of the occupational therapist in South Africa was moulded from its birth by the influences of the medical model.

Some of the remaining examples of this sovereignty and hegemony over the formative years of occupational therapy's development in South Africa, by those doctors who were the various presidents until 1967 will follow. These brief comments will also attempt to demonstrate the subservience, obedience and obvious efforts of Association members to ingratiate themselves with these father- figures. Those quotations which speak for themselves will have very little, if any, comment from the researcher whilst others are discussed or explained in commentary boxes or brackets by the researcher.

1958/59: "Honorary life membership was conferred upon the past 5 presidents of the Association" (with the exception of Mr Pentz, this meant honorary life membership for all previous presidents of the Association since its inception in 1945!)

1960: Newsletter produced by the O.T. dept. at Tara Hospital had a new cover design, "The Trumpet" designed by a Natal member. The name was suggested by Prof.G.T.du Toit. (Orthopaedic Surgeon)

1961: A new constitution was formulated by Dr Mills (1), which emphasised a more national outlook (2) and granted more autonomy to regional groups (3).

It seems extraordinary that the new constitution should again have to be formulated by a medical doctor (1) and here also the possible tensions between the various regions (provinces) are implied by the need for a more national outlook (2) and for greater autonomy (3) needed by regional groups.

1964: Death of President/chairman. Dr Mills who had guided (1) the council of SAAOT for 7 years (2) died suddenly. His generous support (3) of the profession and his friendly but firm (4) guidance at council meetings was greatly appreciated (5) by all members of council who served under his leadership. (6)

This brief epitaph for Dr Mills crystallises the past 21 years of the Association's history. Dr Mills had controlled the administration of the Association (1) for a period of time (2) which is excessive by today's standards of a democratic elective process, his leadership style (3, 4, and 6) suggests a paternalism and patronisation wielded over a rather subservient (5 and 6) group of therapists.

1966: "At Prof du Toit's suggestion, changes to the constitution were approved by the members to allow for the first OT member to be elected as President of SAAOT. The Association had really come of age and no longer needed the guidance of an outside president.

It is again indicative of the lack of confidence of the Association's members that even after 21 years, the suggestion that they should by now be capable of running their own affairs, had to be offered yet again by a doctor!

Control by the South African MEDICAL and DENTAL Council² (SAMDC) over the Profession of Occupational Therapy

The control over occupational therapy's development by the South African Medical and Dental Council was held by these two professions from its inception in 1928 until its replacement by the Interim National Medical and Dental Council in 1992 (64 years), and finally, by the Health Professions' Council of South Africa in 1998. Most other health

² During the apartheid years, the regulatory and controlling body over most health professionals was referred to as the South African Medical and Dental Council (SAMDC). In 1992 during the build up to the democratic election of the new Government in 1994, SAMDC was replaced first by an interim Council, whose job it was to reconsider the entire structure and functioning of the council to allow for greater representation of professional groups and consumers on the Council. It was finally and more appropriately renamed the Health Professions Council of South Africa (HPCSA).

professions falling under the control of the SAMDC were classed as professions supplementary to medicine. van der Reyden describes her recollection of the early years as a member of the professional board for occupational therapists as follows: *“the board was seen to be an august body, doing important work, but viewed as something of a secret society, somewhat detached from the rest of the professional group. The board was also viewed as a body that worked extremely slowly. Correspondence written in the prescribed legal jargon compounded this impression”* (van der Reyden 2003:1)³

According to the Medical, Dental and Supplementary Health Services Act 56 of 1974 (as amended: 753)⁴, chapter 1 describes the “Continued Existence and Objects, Functions and Powers of the South African Medical and Dental Council”. For the purposes of this thesis, I will discuss here only those objects and functions of relevance to the profession of occupational therapy and of significance to my discussion on the influence of control and power over occupational therapy’s knowledge systems.

Under the section describing the *Objects, Functions and Powers*, of the council⁵ most significant are:

” 3(b) ...to control (1), and to exercise authority (2) in respect of all matters affecting the training of persons 3) in, and the manner of the exercise of the practices (4) pursued in connection with, the diagnosis, treatment or prevention of physical or mental defects, illnesses or deficiencies in man (5)”

The stick-wielding sense of power contained in the words ‘control’, ‘exercise’ and ‘authority’ (1) and (2) clearly illustrates the degree of control the SAMDC had over all other professions falling under its authority. It is clear that the intention of the Council was to have complete control over everything we as a profession did. Of even greater concern was that apart from simply exercising this control and authority in an arbitrary manner, it was specifically stated that it would be in authority over the training of

³ van der Reyden D. (2003). **The Professional Board – What is it all about?** Guest Editorial. South African Journal of Occupational Therapy. Volume 33(1):1.

Dain van der Reyden was both a member of the professional board for occupational therapists and later the Chairperson of the Board for occupational therapists and orthotists and prosthetists for a period of nearly 28 years, stretching from 1976 until January 2004.

⁴ South African Medical and Dental Council. Statues of the Republic of South Africa – Medicine, Dentistry and Pharmacy: Medical, Dental and Supplementary Health Professions Act, 1974 (Act 56 of 19.74) (as amended): 751 to 785. Pretoria.

⁵ Ibid: 753-757

occupational therapists (3) and over everything we did in terms of the practice (4) of our profession i.e. related to our treatment and or prevention of illness in the human being. (5). Thus everything we did was to be under this “gaze” of authority and approval or disapproval wielded by the doctors and dentists sitting on the Council of the SAMDC, many of whom, at that time, had little, if any knowledge about occupational therapy and its role in health care, because occupational therapy was a relatively new profession internationally and it was very new in South Africa.

Point 4(f) of the objects of council (1) reads as follows: to “*consider any matter affecting medical, dental or psychology profession or any of the supplementary health service professions (2) and make representations (3) or take such action (4) in connection therewith as the council deems (5) advisable.*”

Under this point, while the professions of medicine, dentistry and psychology are exclusively named, occupational therapy is marginalised within the generic term ‘supplementary health services professions’ (2) a term for a clumped-together group of professions considered supplementary to medicine and thus by implication, inferior to it. The Council (1) was almost entirely comprised of white male doctors and dentists. It was thus this group that represented (3) the profession of occupational therapy (mostly white females) on any issues related both to training and practice, and it was these representatives that took decisions upon what action (4) should be taken regarding training, practice and/or malpractice.

The constitution⁶ of the membership of Council is also of relevance. Twenty-five of the thirty members were doctors and dentists (83%), one was a nurse, one a pharmacist, three were persons not registered under the act, (therefore could not be occupational therapists), and one chairman of a professional board which could be from any one of the so-called supplementary professions, including occupational therapists.

So, for a period of approximately 51 years (1943 to 1994), a council consisting of white (European), predominantly male doctors and dentists held control over the final content

⁶ Ibid:755-756

of the South African occupational therapy curriculum. After the establishment of an occupational therapy board in 1973, there was at least opportunity for occupational therapists to comment on and make submissions to the council regarding the content of curricula and any rules and regulations pertaining to the training of occupational therapists or the profession itself; however, the final “rubber stamp” still came from the council, and I quote *“Any person or educational institution wishing to offer such training as referred to in subsection (1) shall before offering such training, apply to the council in writing for its approval of such training and shall furnish such particulars regarding such training as council may require”*.⁷

Davy's document clearly demonstrates how the control of the SAMDC was exercised over the professional association, for example:

In 1946 “the Association was officially recognised (1) by M&DC (Medical and Dental Council) as the professional organization representing all O.T.'s in South Africa and O.T.'s were then eligible for registration as medical auxiliary (2) [the term paramedical was not used until much later]. The course at Wits was also recognized by M&DC (3)”.

This meant that although occupational therapists as a professional group had the tacit approval (1) of the SAMDC, they were in fact unable to register with the council until the Medical Auxiliaries Bill for compulsory registration had been passed by Parliament. There are two interesting facts that emerge from an analysis of this statement. Firstly, the title medical auxiliary (2) is interesting in that its meaning is described as “*a person or thing that gives help*” (Tulloch, 1993)⁸ or “*giving assistance or support: aiding, helping or subsidiary, supplementary; additional*” (Ilson, 1988)⁹. When attached to the word “medical” the implication is that occupational therapists were perceived by the council, and perceived themselves, as assistants, helpers and subsidiary persons to the doctor. The second fact of note is that the curriculum at the University of the Witwatersrand (3) was approved by the SAMDC. This, then, tells us that even though occupational therapists

⁷ Ibid: 765

⁸ Tulloch, S. (1993). **The Readers Digest Oxford complete word finder**. Readers Digest Association. London.

⁹ Ilson, R. (1988). (Editor). **Readers Digest Universal Dictionary**. Readers Digest Association Ltd. London.

could not as yet register with the SAMDC, they still had their curricula approved by this council.

Ironically, Davy's record of 1947 tells us that the *Medical auxiliaries Bill for compulsory registration* was rejected by Parliament, and we see another offshoot of the ramifying power of the Government of the day making its way into the tiers of control over the development of the profession of occupational therapy. This will be discussed in more detail later in this chapter.

In 1947 a Federated Society of Medical Auxilliaries¹⁰ was formed to work towards parliamentary approval of the bill, which was submitted to, but rejected by, parliament. In 1952 this bill was again rejected by Parliament. In 1958 the collaborative action of Universities training 'supplementary' health professionals who were not yet registered with the SAMDC, and who needed to get their Bills passed by Parliament, formed a council under the acronym of CAMP [although Davy does not give the exact wording for the acronym, it likely that it stood for the Council of Allied Medical Personnel]. This organisation appears to have worked together with the SAMDC to have what was referred to as "the *Supplementary (1) Health Services Bill presented to the Health Minister (2)*". [(1) **Supplementary to Medicine?**] Presumably this (2) meant having it passed by Parliament. In 1965 this Bill was rejected yet again i.e. "[requested (sic)] further support for the Bill, but Minister of Health indicated it would not be discussed this year (3)".

The marginalisation of supplementary health professions and the extent of power exercised by the Government through the Minister of Health and Parliament is evident here where, after seven years, this important matter was still not even 'discussed' (3) let alone being passed as an Act.

¹⁰ According to Davy's document page 2, because the '*Medical Auxiliaries Bill for compulsory Registration was rejected by Parliament in November, a Federated Society of Medical Auxiliaries was formed to work for the acceptance of the Bill in Parliament*'.

It was not until 1972, twenty-seven years later, that Parliament passed an amended SAMDC Act “providing for the eventual compulsory registration of paramedical (1) personnel. The first step towards this goal being the establishment of a professional board (2) for O.T.”

This battle for the eventual passing of the Bill also illustrates the third tier of power i.e. Government and particularly the State Health Department. Here again we see undermining terminology (1) implying occupational therapy’s attachment to the medical profession in the form of para- (beside, beyond, past) MEDICAL (the sovereign). The establishment of a professional board (2) has already been discussed.

Control by the Government and particularly the State Health Department

The control of Government over legislation that permitted registration of occupational therapy as a recognised profession at the time has already been demonstrated in the preceding section i.e. the control it exercised over its decision to pass the Bill allowing “Supplementary” Health Professions to become registered with the SAMDC.

Foucault argues that Governments promote systems which appear to be aimed at caring for people but which rather restrict individual’s rights in line with the dominant ideology.¹¹ The apartheid Government was particularly paternalistic and reductive of women in any professional role. The *woman’s-place-is-in-the-home* doctrine was strongly entrenched and consequently, a newly developing woman’s profession¹² would not have been taken very seriously, which is evident in the following.

Davy’s document has repeated reference to requests to Government to improve salaries and conditions of service for occupational therapists. For example:

1949: “Approaches were made to the State Health Department and supported by the Mental Health Society to improve salaries.”

¹¹ Pitfield, D. **Medicalisation and medical intervention: What does it mean in Practice?** In: Allais, C. (Editor). (1995).

¹² Although occupational therapy today has many more men in the profession, in those days, like nursing, it was considered a women’s profession.

1952: “ Salary scales. Again employing bodies were contacted with a view to improve them [salary scales], especially in the Cape where the scales were lower than in the Tvl. [Transvaal]¹³ .

1955 “Once again representations were made to the State Dept of Health regarding lower salary scales in the Mental Hospitals and again without success (4).

(1) implies that all previous submissions were unsuccessful and thus provides an idea of the degree of (un)importance the State gave to the profession at the time

In 1957, 1965 and 1967 there are entries either discussing discrepancies in salaries between institutions (for example occupational therapists working in psychiatric hospitals got less than those in general hospitals) or discussing further submissions through regional or state departments, all to no avail. It was only in 1978/79, 30 years later that “the Public Service Commission announced salary increases.”

Control over the number and situation of occupational therapy posts was also wielded by the State, and Davy’s document shows the very slow progress made in acquiring occupational therapy posts throughout the country. The Transvaal and Cape appear to have been in the lead with Natal and Orange Free State following some time afterwards. The system was still very discriminatory regarding which provinces should get posts, and how many. This was possibly related to where the seats of political power lay at the time.

[I recall during my employment in both the Natal Provincial Administration (NPA) (1971 to 1975) and the Provincial Administration of the Orange Free State (PAOFS) (1976 to 1981) that both these provinces had significantly fewer posts than did the Cape and Transvaal. In the early years of working in these provinces I remember that hospitals such as H.F. Verwoerd in Pretoria and Groote Schuur in Cape Town had more posts per hospital than the entire post structure for the NPA and PAOFS Occupational Therapy Services.]

¹³ In the apartheid era, South Africa was divided into four main provinces viz. the Transvaal, Orange Free State, Natal and Cape Provinces. Interspersed between these were several “homelands” or parts of South Africa designated for the various black ethnic South African groups. This was part of the separate development policy of those days, thus for example Transkei was designated for Xhosa, KwaZulu for Zulu, Qwa Qwa for Sotho etc.

Regional control over SAAOT

In the early days of the Association the only training centre for occupational therapists was situated at the University of the Witwatersrand, Johannesburg (in what was then called the province of the Transvaal). Apparently because of this, the Transvaal became the centre from which most of the activities guiding the development of the profession were directed in those days. Although there were a few occupational therapists in the Cape, the financial constraints of the association made it impossible to cover the costs of travel for the Cape council members to and from the meetings, which were held every alternate month.

The Cape group only formed a regional branch in 1956 with a membership of 6. But there may have been some resentment and discontent experienced by, other regional groups, particularly the Cape group (of whom Mrs Davy was a member), towards the Transvaal group. She tells us that in 1952 “*Again employing bodies were contacted with a view to improving them (salaries) especially in the Cape where the scales were lower than in the Transvaal.*” By 1965 this matter had still not been resolved and must have caused some resentment between regions

In 1969/70 Mrs Davy was elected president of the Association, and she states: “for the first time (1) a Cape member elected as President.”

The fact that it took the Association 25 years to move the presidency out of the Transvaal is indicative of the greater power of the Transvaal Regional Group of SAAOT at the time.

The fact that power was situated mostly in the Transvaal and Cape provinces, coupled with the political forces in favour of the historically white universities (HWU's)¹⁴ at the time, also affected the power behind the motivation and approval for the establishment of occupational therapy training courses over the years from the Association's birth. Historically, the Association was responsible for motivating for the commencement of

¹⁴ Historically White Universities (HWU's) were those universities that had been established in the early colonial days and apartheid era, to provide tertiary education for exclusively white students. Later, when the apartheid government was under pressure from the rest of the world, some token places were given to people of coloured, Indian and Black races.

new occupational therapy courses through the SAMDC who would, in turn, make recommendations to the specific university for which the Association had submitted a motivation. Thus it was that sequentially training centres were established first in the Transvaal, followed by the Cape (all of which were HWU's) and lastly, decades later, occupational therapy training was established in the historically black universities (HBU's)¹⁵.

According to Davy's document, the sequence of establishment of occupational therapy training courses was as follows:

1944/45	University of the Witwatersrand (HWU)
1956	Pretoria College of Occupational Therapy (HWU)
1961	University of Stellenbosch (HWU)
1971	University of Cape Town (HWU)
1976	University of the Orange Free State (HWU)
1977	Medical University of South Africa (HBU)
1981	University of Durban-Westville (HBU)
1982	University of Western Cape (HBU)

Davy indicates that as far back as the 1950's the University of Natal was approached by the association to attempt to commence occupational therapy training, which is intimated in the item below:

"1957 OT Training: both UCT and Stellenbosch Univ indicated interest in O.T. training and Council once again (1) approached Natal University." Although prior events are not recorded in Davy's document, this statement (1) implies that prior to 1957 there had been some negotiations with Natal University. Then again in 1959 the "University of Natal was again approached regarding training of non-whites (2)".

¹⁵ Historically Black Universities (HBU's) were those that were created by the apartheid government to segregate and accommodate the tertiary education of races other than white. These institutions were created to further segregate the so-called non-white groups. Thus the Medical University of South Africa was for Black Africans, the University of Durban-Westville for Indians and the University of Western Cape for people of mixed race.

This stipulation that training should be for non-whites (2) is indicative of the concern of OT's in those days to try and get this much needed training underway. However, one wonders why training for 'non-whites' should have been restricted to Natal and not extended to other regional groups.

It is quite astounding to think that it took another nearly 25 years before this Association eventually succeeded in establishing training in Kwa-Zulu Natal in 1981.

Sequence of regional group formation

By 1961 the Transvaal group appears to have become too unwieldy and was split into two regional groups viz. the Southern (or Central) and Northern Transvaal regional groups. The formation of regional groups in the other provinces occurred much later after the creation of occupational therapy posts in these groups. The first post was created in Natal Region in 1949, with the Natal regional group only being formed 11 years later in 1960. The first occupational therapy posts in the Orange Free State (OFS) were only created and filled during the period 1968 to 1969, and the Orange Free State/ Northern Cape regional group was finally formed during the period 1970-1971.

Table 5 below, provides a linear-chronological, colour-coded layout of the history of sources of control within the development of occupational therapy in South Africa.

Key: Control over presidency = Shades of grey
Control by Government = Shades of blue
Regional control = Shades of lilac
Control over training = Shades of green

YEAR	45	47	49	51	53	55	57	59	61	63	65	67	69	71	73	75	77	79	81	83	85	87	89	91	93	94	
Presidency of SAAOT	President of SAAOT is a doctor or psychiatrist											1966 first OT elected as president of SAAOT															
Governance	SAM&DC Controls registration and training of occupational therapists														Professional board for OT established but rubber stamping of OT curricula and regulations still under a predominantly male/doctor control												
Regional Control	The Transvaal region dominates as members of the EXCO of SAAOT and of leadership of OT											Transvaal OT regional group splits into Northern and Southern Transvaal regional groups															
							Cape regional group formed in 1956																				
							Natal regional group formed in 1960																				
																	OFS & N. Cape regional group formed in 1970/71										
Of OT training	Occupational therapy training commences at the University of the Witwatersrand																										
HWU								Occupational therapy training commences at the Pretoria College of Occupational Therapy																			
HWU											Occupational therapy training commences at the University of Stellenbosch																
HWU																					Occupational therapy training commences at the University of Cape Town						
HBU																					Occupational therapy training commences at MEDUNSA						
HBU																					Occupational therapy training commences at the University of Durban - Westville						
HBU																					Occupational therapy training commences at the University of the Western Cape						

TABLE 5: LINEAR-CHRONOLOGICAL HISTORY OF SOURCES OF DOMINANCE OR CONTROL OF /OR WITHIN THE DEVELOPMENT OF OCCUPATIONAL THERAPY IN SOUTH AFRICA FROM 1945 TO 1994

SECTION 2:

A brief historical review of occupational therapy and its origins in the rest of the world

This review will briefly look at the origins of the use of activity/occupation to promote healing and well being, then summarise the history of occupational therapy from both British and American perspectives as these two countries were where it found its name and from whence it spread to most other countries, including South Africa.

Early days

Some of the first references to the use of occupation as a form of 'treatment' go back as far as 600B.C. when Aesculapius, the God of Greek medicine, was said to have quieted delirium with songs, farces and music. Orpheus, Pythagoras and Thales all used music to remedy ills. Hippocrates recommended wrestling, riding and 'labour' (meaning strong exercise) except for acute conditions. And apparently Cornelius Celsus, apart from his contribution to the study of anatomy and medicine, recommended 'occupational exercise' for maintaining health, examples of which were sailing, hunting, handling of arms, ball games, running and walking. In addition to this he also prescribed reading aloud for a weak stomach¹⁶.

During the lull of the Dark Ages (A.D. 200-1250), a fifth century neurologist described active and passive treatment of all kinds for all types of paralysis. These included many physiotherapeutic techniques such as heat applications and speech therapy¹⁷. Tales of similar fleeting interests in occupation as a treatment medium by various persons are recorded throughout medical history, and right up until the actual establishment of occupational therapy as a profession. But what is of particular significance to this study is that all these people were men, and almost all were either doctors or psychiatrists.

Foucault¹⁸ reminds us that the edict of the creation of the general hospital was to prevent "*mendicancy and idleness as sources of all disorder*": 53. Thus, labour in these houses of confinement assumed its ethical meaning, which was that because idleness (sloth)

¹⁶ MacDonald, E.M. MacCaul, G. Mirrey, L. & Morrison, E. Occupational therapy in rehabilitation, its history and place in health and social services today. In: MacDonald, E.M. MacCaul, G. Mirrey, L. & Morrison, E. (Editors). (1978).

¹⁷ Ibid

¹⁸ Foucault, M. The great confinement. In: Foucault, M. (2002).

had become the absolute form of rebellion, those who were idle would be forced to work, incessantly in the endless leisure of labour without the reward of payment. ‘*Madmen*’ (people with psychiatric illness) were also included in this proscription of idleness. It is interesting that, in these early days, the intention of occupational programmes implemented in such institutions, was punitive rather than therapeutic.

Global roots of occupational therapy

Dunton traces the roots of occupational therapy back to a philosophical movement originating in Europe in the nineteenth century known as **moral treatment**. Philippe Pinel proposed a moral revolution in France to replace the view that individuals with mental illness were dangerous, incurable and should be locked away in chains. He rather recommended that they should be locked away using a more humanitarian approach of kindness and a regimen of daily life that consisted of creative and recreational occupations to restore health¹⁹. “*It was within the walls of confinement that Pinel and nineteenth century psychiatry would come upon madmen; it is there - let us remember - that they would leave them, not without boasting of having ‘delivered’ them*” (Foucault 2002:36)²⁰. This comment by Foucault echoes a recurring pattern of patronisation by health professionals of people who are disempowered by physical or mental illness or injury.

MacDonald *et al* (1978)²¹ tell us that from 1850 onwards there was a gradual emergence of the various ‘*supplementary treatment services*’ as professions and, between then and 1978, there emerged the formation of associations, and the institution of training, and of recognised examinations and qualifications. The latter part of the nineteenth century saw women taking up careers and, at the turn of this century, being accepted into professions. It was the Crimean war (1854 -1956) that hastened the establishment of nursing, the First World War (1914 -1918) that of physiotherapy and a bit of occupational therapy and then, finally, the Second World War (1939 -1945) which saw occupational therapy came into its own in the United Kingdom. By the end of the nineteenth century

¹⁹ According to Schwartz, K.B. (2003:5), William Rush Dunton wrote the first history of occupational therapy for the first edition of Willard and Spackman's Occupational Therapy, in 1947.

²⁰ Michel Foucault (2002) The great confinement. In: Foucault, M. (2002).

²¹ MacDonald E.M, *et al* (1978).

occupational therapy was practised, albeit in different forms, in the United States, Britain, Canada and several countries in Europe.

Schwartz²² describes moral treatment hospitals in the United States that were equipped with craft shops, garden- and recreational areas specifically to promote occupational engagement. It appears that William Rush Dunton, a psychiatrist, is seen as the “*father of occupational therapy*” (Schwartz, 2003:6) in the USA, and this same gentleman supervised the *occupation* classes at Sheppard Pratt Hospital in Maryland. It was he who proposed that occupational therapy represented the continuum of the **moral treatment** approach to the mentally ill which was started by Pinnel in Europe in the previous century, and of which Foucault was so critical.

The National Society for the promotion of occupational therapy was founded in the USA on 17 March 1917. The founders were of four women: Susan Cox Johnson (arts and crafts instructress), Eleanor Clarke Slagle (welfare worker), Isabelle Newton and Susan E. Tracy; and four men: William Rush Dunton (psychiatrist), George Edward Barton (architect), Thomas Bessell Kidner (vocational secretary and former architect) and Herbert James Hall. The professions of the others are not stipulated (Schwartz, 2003).

One of Dunton’s and Slagle’s mentors, Adolf Meyer, who was a professor of psychiatry at Johns Hopkins University, took the fundamental ideas of moral treatment, built on them and created what he called a philosophy of *occupation therapy*. He maintained that mental illness was largely a problem of adaptation, habit deterioration, and lack of balance of work and play. He incorporated the habit training programmes that Slagle had been using and therapeutic programmes designed to provide opportunities for mentally ill people to engage in pleasurable, creative and educational occupations²³.

Of further relevance to this chapter is Black’s²⁴ description of early American occupational therapists: “*when occupational therapy was in its infancy during the second decade of the 20th Century, the first occupational therapists were single, white, highly educated young women identified as society girls*” (Black, 2002: 141), she goes on to

²² Schwartz, K.B. The history of occupational therapy. In: Crepeau, E. Cohn E. & Boyt Schell, B. (Editors) (2003).

²³ Ibid

²⁴ Black, R.M. (2002) Occupational **Therapy’s Dance with Destiny**. American Journal of Occupational Therapy Volume 56(2): 140-148.

state that they were influenced by the upper-middle and upper class American values and cultural tradition as well by what she refers to as the “*progressive philosophy*” (Black, 2002:141) of the twentieth century. Their motivation for joining the profession was to make a difference in the lives of those who were sick and injured.

Black maintains that, although the occupational therapy of those days emphasised the individuality of the patient, “*little, if any, emphasis went into understanding the socio-cultural background of each patient and how that background might influence activity choice*” (Black, 2002:141) and, further, that the activities chosen for therapy in those days more often reflected the interests of the therapists who used them than the interests and inclinations of the patients who needed them²⁵. One cannot help wondering how therapeutic the activities of this ‘elite’ group of therapists could have been to the ‘ordinary’ soldiers and man in the street, that they were ‘treating’. Black’s statement resonates in one of Dart’s²⁶ early descriptions of the beginnings of occupational therapy in South Africa. He tells us that “*in those days nearly every European woman was knitting ... (one day, two ‘would-be occupational therapist’ women doctors) were pained by the spectacle of the Bantu men with tuberculosis, lying there day by day awaiting the inevitable death that had already overtaken one of them. (and) had enlightened their days bit by bit by showing them how to knit*” (Dart, 1963:3). There is little doubt that these desperate men probably benefited from the knitting, which would have distracted them from the “*inevitable death*” (Dart 1963:3) awaiting them, but the total lack of sensitivity to gender and cultural appropriateness of the activity is, to say the least, mind-boggling.

Let me now return to what was going on in the United Kingdom at this time. MacDonald *et al* (1978)²⁷ mentions that the impetus of using occupation as a curative measure for the war-wounded, to improve performance components such as muscle strength and endurance was not maintained and, until the late 1920’s, occupational therapy was mostly practised in psychiatric institutions. The first British school of occupational therapy was founded in Bristol in 1930. In 1936 the Association of Occupational Therapists in England was formed and this later became the British Association of Occupational

²⁵ *ibid*

²⁶ Dart, R.A. (1963). **The initiation of occupational therapy in South Africa**. South African Journal of Occupational Therapy. Volume 1(8):4-6.

²⁷ Quote from the Professions Supplementary to Medicine Act of 1960. In: MacDonald, *et al*. Occupational therapy in rehabilitation, its history and place in health and social services today. In: MacDonald, E.M. MacCaul, G. Mirrey, L. & Morrison, E. (Editors). (1978).

Therapists in 1974. The World Federation of Occupational Therapists (WFOT) was founded in 1951.

Compulsory State Registration under the *Professions Supplementary to Medicine (1) Act* of 1960 was seen by British occupational therapists as *giving “official recognition (2) to this and allied professions (2), and has through each Professional Board, linked state and professional interest and responsibilities for promoting high standards of professional education and professional conduct in the Health and Social services”* (McDonald *et al*, 1978:141)²⁸. Echoes of the South African history resound in the subjugatory discourse evident within this Act.

The study of the human occupation in its holistic sense has, over the past twenty years, seen the development of occupational science, which is the study of humans as occupational beings (Wilcock 1998)²⁹. Occupational science emerged in the 1980's as an academic discipline and is distinguished from the profession of occupational therapy as such.

Still the controlling influence of the scientifically oriented medical community would not tolerate the anecdotal evidence and intuitive conviction of the benefits of occupation to human health that occupational therapists espoused, and it was clear that more scientific evidence was needed to convince the scientific community of this. And while medicine itself did not have all the answers, it “*set the scientific standard that all health professions had to meet if they were to succeed in the medical community*” (Schwartz, 2003:10)³⁰. So it was that health was gauged purely upon the medical perspectives of what should define health at the time.

It was only in the 1960's that two very powerful American occupational therapists, Elizabeth Yerxa and Mary Reilly, began to argue that the rapid growth of the profession, leading to more specialisation within the field, and its increasing recognition within the medical sciences brought it into conflict with some of the founding ideals of the profession. They were particularly concerned that, through this medical affiliation and its movement towards specialisation, the profession was losing its focus on holistic,

²⁸ *ibid*

²⁹ Wilcock, A. Introduction. In: Wilcock, A. (Editor) (1998).

³⁰ Schwartz K.B (2003).

humanistic, occupation-centred treatment³¹. These concerns have subsequently given rise to a plethora of progressive perspectives from both young and older therapists across the globe who challenge some of the early occupational therapy dogmas and suggest some new and very challenging changes for the future [Grady, 1995; Kelly, 1996; Watson, 1997; Wilcock, 1999; Yerxa, 2000; Whiteford 2000; Wilcock, 2001; Weinblatt *et al*, 2001; Whiteford, 2001; Lorenzo, 2004; Watson and Lagerdien, 2004); Kronenberg *et al*, 2005b; Algado, 2005; Awaad, 2003; Odawara, 2005; Iwama, 2003; Iwama, 2004; Iwama 2005b; Townsend and Whiteford, 2005; Duncan *et al*, 2005; 2005; and Galvaan, 2005].

This summary of the history of the development of occupational therapy as a profession first reveals how human occupation was perceived to have a positive effect upon human health, especially that of people with mental illness and, later, how this treatment³² became formalised into the profession. It also reveals some significant similarities and parallels in the development of the profession in South Africa and other parts of the world - parallels that are highly relevant to this thesis.

Eurocentric influences

Firstly, Davy's (2002)³³ document reveals that most, if not all, the original occupational therapy pioneers in South Africa were from the United Kingdom. These women not only contributed towards the development of the professional association but, for at least the first 10 years of the professional association's history, British therapists held the position of vice-chair on the executive committee of the Association, which, you will recall from Chapter 3, was a position directly under the president and chairman; a position which was filled for the first 22 years by either a medical doctor or psychiatrist. British occupational therapists also held positions as lecturers in the University of the Witwatersrand and Pretoria training courses for at least the first ten years of these two courses' existence.

³¹ Ibid

³² The word 'treatment', synonymous with the medical model, is appropriate in this context although it is loaded with paternalistic and patronising connotations. This will be discussed in more detail in Chapter 8.

³³ See pages 56 and 57 of this chapter.

The umbilical cord of these pioneers to the United Kingdom appears to have remained fairly firmly attached, because many of them either returned to their mother country permanently after a short while, or regularly returned for lengthy holidays.

The following are some examples of how this pattern is revealed in the text of the Davy document:

1945: Miss Drabble and Mrs Stout returned to the U.K. (1) and Miss Dudley-Smith arrived to direct the course (2).

It appears that (2) is referring to the Red Cross course for voluntary craft workers. In these early years there were apparently no South African occupational therapists capable of running occupational therapy services and so, as one British-trained therapist returned 'home' (1), she was replaced by another (2).

Tobias³⁴, in recounting the history of occupational therapy in South Africa recalls that the first two lecturers appointed to run the first occupational therapy training at the University of Witwatersrand in 1942 were a *'Miss Crousaz and Ms I. McArthur, both of whom had received their training in England ... between the two of them these two... ladies had carried ten classes of diplomats through to the consummation of their OT courses.'* 1946: The four members of the Association (all British) were joined by three O.T's from the U.K.

It seems that the current group needed reinforcements and these were recruited from the UK

Haden³⁵ (1953), in the very first article of the very first South African Journal of Occupational Therapists, tells us that *"during the past ten years, the course³⁶ has turned out 43 occupational therapists, a number which is far too small to meet the growing needs of the country. At the beginning, trained staff were imported from England ... Messrs Crousaz and McArthur ... were succeeded by Miss K Barber who had done a lot of work in British Naval Hospitals".*

³⁴ Tobias, P.V. (1982). **The past and future of occupational therapy.** The Vona du Toit Memorial Lecture. South African Journal of Occupational Therapy. Volume 12(2): 6-18.

³⁵ Haden, H. (1953). **Occupational therapy, 1943-1953.** South African Journal of Occupational Therapy. Volume 1(1): 1- 2

³⁶ This refers to the first occupational therapy training course at the University of the Witwatersrand.

1947: Mrs J Hart arrived (from U.K.) to fill Miss Turner's (who was also from the UK) post while the latter was on overseas (in the UK) leave.

An echo of the 1945 situation.

1948: Miss Hilton-Barber arrived from the U.K. to open the department at Baragwanath Hospital.

What is interesting about this is that, rather than one of the existing UK therapists, who would have had a bit more experience of the South African situation and diversity of cultural groups being appointed, yet another British therapist was recruited to come and start the new department at Baragwanath Hospital which, in those days, was specifically built by the apartheid regime for 'non-whites'. This therapist would have brought with her little, if any, understanding of local, African cultures and needs in terms of occupation and health

1949: Miss Steadman from the U.K. was employed by the Red Cross Society to supervise voluntary craft workers working in T.B. hospitals in the Cape Town area.

1952: Miss Steadman represented SAAOT at the international federation meeting in Liverpool which resulted in the formation of the World Federation of Occupational Therapists (WFOT). SA became a founder member.

1955: Pretoria. Miss O. Rayne from U.K. established the 3½-year course of O.T [i.e. the Pretoria College of Occupational Therapy] and later Miss J. Bald from U.K. followed to assist her.

Here again we see the repetitious system of replacement of one head of training from UK who appears to have been specially brought out for the purpose. One would imagine that by this stage i.e. 10 years later, some of the South African OT's, who must have been qualified for at least 5 or 6 years, would have been better suited for the position albeit that they were white OT's.

1957: Pretoria College: Miss Rayne left SA for Australia and Miss J Bald took over the direction of the course.

Miss Bald remained head of this department until 1962 when the first South African, Vona du Toit³⁷, took over as head of this training.

Patriarchal influences

The second significant point of similarity between the South African history of occupational therapy and that of Britain and America is the fact that the origins of occupational therapy were conceived mostly by male, medically-oriented Europeans who believed in the therapeutic and healing potential innate in human occupation. Certainly the founding of the profession *per se* was largely brought about by the initiative of medically oriented males. One has to assume, then, that the development of this core knowledge base was based upon the ideological backgrounds of the white, European, British or American men who were responsible for giving birth to occupational therapy³⁸.

Founding persons nationally and internationally such as Dart, Moross and Dunton also appear to have spoken on behalf of the profession at public occasions, seminars and conferences in the early days. For example Schwartz (2003)³⁹ refers to how Professor Dunton (USA), through his prolific writing and numerous professional presentations, was a leading advocate for occupational therapy.

According to Davy's records (2000), (previously mentioned) at a symposium held in 1956 in Johannesburg, on "*What to expect from the occupational therapist*", all presentations were given by members of the medical profession. Simmons⁴⁰ also mentions this in her report to council the following year where she reveals that this symposium was in fact part of a fund raising drive for SAAOT. It is possible to speculate that an array of presenting male doctors would have been a better draw-card than an array of female therapists from a little known, newly developing profession. But the most

³⁷ Vona du Toit went on to become one of South Africa's most famous pioneers. She was a very dynamic lady who was involved on both national and international levels (becoming vice-president of WFOT) and was involved in two significant developments: the model of Creative Participation, which is still used extensively today in South Africa, and is becoming internationally popular. And, together with Ilse Eggars, Vona was responsible for the development of the Pretoria Multi Motivational Therapeutic Apparatus (PMMTA), the principle of which is used extensively in the OT world today.

³⁸ Pillay (2003): 23-24 demonstrates a very similar phenomenon in his representation of the pioneering practitioners who gave birth to speech and language therapy.

³⁹ Schwartz (2003) page 5

⁴⁰ Simmons, J. (1957). **Report on Council Activities 1956-57**. South African Journal of Occupational Therapy, Volume 1(5): 2.

significant fact remains that, although occupational therapists organised the entire symposium, members of the medical profession were called upon to represent *what was to be expected of occupational therapists* at that stage. This is indicative, not only of the dependency of the therapists at the time, but also the sovereignty of the male-dominated, medical model way of knowing, over occupational therapy's emerging way of knowing.

This subjugation of our knowledge in the early years is further revealed by a perusal of the status of the eleven authors who contributed to the first Volume of the South African Journal of Occupational Therapists Volume 1 Number 1 published in August 1953. Six of these were contributed by medical doctors or psychiatrists, and only five by occupational therapists.

Pillay's (2003)⁴¹ reference to the allegiance or affiliation with male-centred ways of knowing, male epistemologies and male ideologies as a form of androcentrism has already been noted (see page 70). Similarly, Hunt (1998)⁴² develops the analogy between the oppressive socialisation of women, and that of nurses, an analogy which examines, among other things, the patriarchal power base of nursing. Colliere (1986)⁴³ tells us that the recorded history of women was made by men and thus it was men who decided what may or may not be written about women. In this way, men defined the roles first of women, and then of nurses '*according to the influence of their patriarchal views on society's structure*' (Hunt, 1998:3)⁴⁴. Women were given the knowledge men thought they should have because in the early history of writing it was men (priests, clerks and doctors) who controlled access to writing.

Yerxa (1995)⁴⁵ explains that in the early history of the development of occupational therapy in the United States of America, the Deans of Allied Health (read OT, physio- and speech therapy) were usually males with doctorates from disciplines other than

⁴¹ Pillay (2003)

⁴² Hunt, J. (1998). Feminism and Nursing.

<http://www.clininfo.health.nsw.gov.au/hospolic/stvincents/stvin98/a5.html>

⁴³ Collier, M. (1986). **Invisible care and invisible women as health care providers.** International Journal of Nursing Studies. Volume 23(2):95-112

⁴⁴ Hunt, J (1998)

⁴⁵ Yerxa, E.J. (1995). **Who is the keeper of occupational therapy's practice and knowledge?** American Journal of Occupational Therapy. 49(4): 295-299.

occupational therapy. These Deans represented all schools of discipline, including occupational therapy, and wielded decision-making powers over the degrees and curricula offered. They also formed the national organisation that attempted to influence the status and accreditation of occupational therapy in those days.

Hospitals became hierarchical systems with doctors at the apex, followed by nurses in descending level of importance. The repercussions of this configuration are still felt by nurses, health care workers and patients today. Hospitals developed into job-specific and gender-specific environments with male doctors and female nurses.⁴⁶ Occupational therapists in the early days of their development were often put under the control of matrons of hospitals and thus they fell even lower in this male-dominated gender-specific hierarchy with a dominant echelon of males at the top and matriarchal matrons next. On the first page of her history of OTASA, Davy records that Miss Iris Marwick was made one of the first presidents of the Association; she was then the matron of Tara Hospital in Johannesburg.

Postcard #3: Bombs and matriarchs – The early history of occupational therapy in UK was dominated by matriarchal matrons whose code of discipline superseded almost everything else. I recall an amusing story told me by Ms Tish Hinton-Knowles, also a UK trained OT, who had been head of department at the University of the Witwatersrand in 1963 and later came to work in Natal where I met her in the early 1970's when I had recently completed my training. She recounted how, as a newly qualified occupational therapists working in a country hospital in the UK, she had been returning to work on her bicycle after doing some shopping during her lunch break in the nearby village. It was during the Second World War, and while she was cycling along the village road, the air raid sirens sounded all around and German aircraft started bombing the area. A bomb was dropped fairly close to the road, the impact of which knocked her flying off her bicycle and into a ditch on the side of the road. In those days OT's wore white uniforms rather like the nurses' and, as can be imagined, she emerged from this ditch not only in physical disarray with her hair all over the place and several grazes and bruises, but with her uniform covered in mud. When she arrived back at the hospital where she worked, she was greeted by her immediate superior, a very angry matron, who proceeded to reprimand her most indignantly for not only being late but for her dishevelled appearance. Not a question was asked as to her safety, or whether she had been injured.

⁴⁶ Hunt (1998).

History of health care in South Africa and how it influenced the development of occupational therapy

Throughout most colonised countries such as India, Africa, Australia and South America traditional healers have, in the past, been the major providers of health care. Even today they still form an important alternative to orthodox health care, often serving as the principle caregivers for isolated populations. Prior to the 19th century, western doctors linked to trading companies served the European populations almost exclusively. Hence, throughout the colonial period, public health activities were almost exclusively directed at combating disease or attempting to maintain a healthier work force amongst the European population. Thus, by the end of the colonial period, the pattern of health care that had developed in colonised countries was predominantly modelled upon the high technology and urban/institution-based curative care system of industrialised countries. The needs of people in rural areas and slums were largely neglected⁴⁷.

This situation was no different in South Africa and was exacerbated throughout the apartheid years, because the Government of those times developed a health care system, which promulgated racist legislation and the creation of institutions such as political and statutory bodies for the control of the health care professions and facilities. These were built and managed specifically to sustain racial segregation and discrimination in health care, resulting in a highly fragmented, inefficient and inequitable health care system that was biased towards curative care and the private sector. There was very little emphasis on health and its maintenance, and considerable emphasis on medical care⁴⁸.

Because this system focussed mostly on tertiary care within urban hospitals, access to tertiary health care for disadvantaged rural populations very difficult and necessitated their removal from their communities to hospitals often situated hundreds of miles from the security of their homes and communities. It also meant that rehabilitation, which ideally should be focussed more on community-based service, was not. For nearly the

⁴⁷ Werner, D. & Saunders, D. The historical failures and accomplishments of the western medical model in the third world. In: Werner, D. & Saunders, D. (Editors). (1997).

⁴⁸ African National Congress (ANC). (1994). **A National Health Plan for South Africa**. Prepared by the ANC with the technical support of the World Health Organisation and UNICEF. ANC. Johannesburg.

first fifty years of its existence in South Africa, occupational therapy was confined almost exclusively to practise within urban, institutional settings.

As previously discussed, this system also lent itself strongly to the male-dominated, medical model's influence of the early days which permeated every structure that could exert influence and control over the system. This is further reflected in the SAMDC Rules specifying the acts or omissions in respect of which disciplinary steps may be taken by the professional board for occupational therapy and the council, stipulated under Rule 21: Performance of Professional Acts by Occupational Therapists that: '*the treatment of any patient (may not occur) unless that patient has been referred by a registered medical practitioner*⁴⁹'. This rule had been in force since the inception of occupational therapy although it was only stipulated in regulatory form at the establishment of the Professional Board for Occupational Therapists in 1976. Thus, speculatively, even if the individual could have benefited from occupational therapy in the past, a medical doctor who might have little if any knowledge about the role of occupational therapy was in a position to sanction or not sanction therapy for such an individual.

Although occupational therapy services were created for all population groups, these were segregated into white and non-white hospitals. Some of the non-white hospitals were situated in areas that were far from the white residential areas and many were situated close to the equally segregated and infamous African townships. Consequently, there was amongst many white occupational therapists a tacit avoidance of working in these hospitals, either because of fear for their personal safety, particularly travelling to and from these institutions, or because of the inconvenience of having to travel long distances from their homes in white suburbs. However, there were also many genuinely caring and concerned white therapists who made the effort to travel the long distances and risked being exposed to the perceived dangers⁵⁰ in order to provide a service in these hospitals.

⁴⁹ South African Medical & Dental Council. The Regulations Relating to the Constitution, Functions, Powers and Duties of the Professional Board for Occupational Therapy (1976) No. R 2287 of 3 December 1976:278 – 323.Pretoria.

⁵⁰ In the apartheid era, incidents in which whites were attacked when in African homelands and townships did occur. This was not a common occurrence and such incidents were statistically probably no more frequent than attacks by criminals against black people in these areas, but any attack on a white person was given considerable media coverage. This situation created the perception that such attacks were common and that fears of travelling in these areas were therefore justified.

Occupational therapy training produced white therapists exclusively for the first 30 years of its existence until the nineteen seventies. Small numbers of therapists of other race groups only really started emerging in the early eighties after training had been established at the Historically Black Universities. By this time, Historically White Universities were also producing very small numbers of therapists other than white. This skewed profile persists today with the majority of intake at these universities still being white students. Here again, the perpetuation of a white, European hegemony over our South African occupational therapy epistemology is evident.

As a result of the combination of these factors and circumstances, early occupational therapy training was forced to be focussed within the very unnatural situation created by our socio-political circumstances. It was mostly situated in hospitals, psychiatric and other institutions when it should have been mostly situated in the community, where realistic and appropriate rehabilitation occurs. OT was mostly curative and rehabilitation based, with rehabilitation occurring within simulated rather than real situations. There was little emphasis on preventive, integrative⁵¹ and promotive interventions. White population groups were treated in better-equipped and better-staffed institutions, which went against the code of ethics of occupational therapists at the time. The majority of Black people needing rehabilitation were unable to access it because of a shortage of facilities and therapists, and many blacks in rural areas had no access at all to rehabilitation. Those that did receive it had no choice but to be treated by white women who rarely could speak their language and had very little knowledge about those aspects of African culture important to such rehabilitation contexts.

Hooper and Wood (2002)⁵² demonstrate that this dichotomy is a global phenomenon by examining the role which discourse has played in the profession's evolution. They discuss two different discourses i.e. firstly, that which concentrates on restoring persons to satisfying lives and secondly, that which concentrates on fixing the body parts (biomechanical).

⁵¹ Current community-based occupational therapy practice is based upon the need to facilitate the integration of people with disabilities back into their community and everyday lives.

⁵² Hooper, B. & Wood, W. (2002). **Pragmatism and structuralism in occupational therapy: The long conversation.** American Journal of Occupational Therapy. Volume 56(1):40-50.

In the executive summary of the Integrated National Disability Strategy⁵³ the author comments that in the past, and still today, disability has tended to be couched within a medical and welfare framework and is discriminatory towards people with disabilities, and because of the emphasis on the medical side of care, there has been a neglect of their wider social needs⁵⁴.

The preceding chapters have taken us on a journey that has attempted to reveal the roots of occupational therapy in South Africa and briefly, also, the rest of the world. It has attempted to provide an accurate summary of our origins and the factors influencing them. In the process I have expressed my concern regarding the not always beneficial influences of the medical model upon the development of occupational therapy's knowledge, the hegemony of the male doctors/psychiatrists who conceived the profession, and the white European ladies who developed and practised it in the early days. However, while these influences have resulted in flaws in the ideological foundations of the profession in South Africa, it is not the intention this thesis to demonise any of those people or professions responsible.

Occupational therapy would not exist had it not been for the foresight and influence of those medical men; occupational therapy in South Africa would not exist had it not been for the dedication and courage of those white European ladies. Many of them made considerable sacrifices to be here. Mountford (2006)⁵⁵, herself an early pioneer, gives a taste of this in her description of Elizabeth Riddell Turner's existence as the first occupational therapist in the Cape: *"even for a pioneer the obstacles were daunting. Accommodation was totally unsuitable. There were no other staff, materials, tools or remedial equipment and, naturally, little knowledge of the profession amongst other health personnel"* (Mountford, 2006:12). As a profession we should thus be eternally grateful to them. I have no doubt that most of their intentions were honourable and good and that they were not constantly, consciously aware of their respective roles in the

⁵³ **Integrated National Disability Strategy, (INDS).** (November 1997). The White Paper of the Office of the Deputy President. Rustica Press. Republic of South Africa.

The (INDS), November 1997, proposes the vision of a society for all in which people with disabilities should be integrated into society and policies developed to promote this.

⁵⁴ Mbeki, T. (1997). **Executive Summary, Integrated National Disability Strategy.** White Paper of the Office of the Deputy President of South Africa, November. Rustica Press (Pty) Ltd, Ndabeni. Western Cape.

⁵⁵ Mountford, S. (2006) **Obituary: Elizabeth Riddell Turner.** Focus, Official Newsletter of OTASA. Volume 2:12.

history that unfolded to bring occupational therapy to where it is today. And however vociferously one may want to criticise the apparent passivity of later therapists under the apartheid system, one needs to pause and reflect on what would have happened to the profession had we provided a unified resistance. In retrospect, and with the insights into the horrors revealed in the Truth and Reconciliation Commission⁵⁶ about what the apartheid forces did to those who resisted them, it is highly likely that had we collectively done so, occupational therapy would not have existed in this country today.

However, apartheid had a way of encouraging those who were privileged by it to justify this privilege, creating a perception that *all whites* were part of the underlying ideology by virtue of their lack of adequate opposition to it. It is therefore also possible that a sustained and intense critique of it, as part of a collective opposition with others, would have led to a speedier toppling of this underlying ideology and apartheid as a whole.

Vignette # 2- Assault by torchlight.

New Year's Eve 1974, 23h30. Having celebrated quietly over dinner with family and the special man in my life at that particular moment in my history. The two of us had parked next to the Umsunduzi River in Alfred Park, Pietermaritzburg, to spend some quiet time, before he returned to his farm in the Midlands, reflecting together on the past year and waiting for midnight. Midnight struck and he leaned over to hug and kiss me. At that moment a car seemed to appear from nowhere next to us, the doors flew open and two policemen jumped out and shone their bright and intrusive torch lights through the window at us for what seemed like minutes. As quickly as they had come they jumped back into their car and drove off. I asked in absolute horror, "What was all that about?" He replied, "They are just checking to see that we aren't breaking the immorality act" ⁵⁷ [See footnote 56 italics below].

Having explored the roots of occupational therapy the next chapter will look in more detail at the influences of the philosophical and ideological frameworks underpinning them.

⁵⁶ The South African Truth and Reconciliation Commission (TRC) "was set up by the Government of National Unity to help deal with what happened under apartheid. The conflict during this period resulted in violence and human rights abuses from all sides. No section of the society escaped these abuses" The Truth and Reconciliation Commission Website (2003:1). <http://www.doj.gov.za/trc/>

⁵⁷ The Immorality Act, or as it was legally known, the *Prohibition of Mixed Marriages Act* was one of the first pieces of apartheid legislation and came into effect in 1949. It basically banned both 'mixed' marriages and sexual relations (i.e. any marriage of/ or sexual relationship between black or brown skin races with whites). [Saunders, C. 1992]. One of the tasks of the police was to cruise around looking for cars parked discreetly at night, to check that their occupants were not breaking the 'Immorality Act'. People found 'guilty' of this were immediately arrested.

CHAPTER FIVE

Human Beings and Human Occupation - the Core of Being Human? Viewed from a Feminist Perspective

Route map: This chapter will attempt to scrutinise the whole *raison d'être* of occupational therapy, particularly as it is perceived today, and how important it is as a state of the art and really progressive form of providing independence and greater quality of life for those with severe physical and mental impairment. In addition to this and by virtue of their unique knowledge of human occupation and its benefits in restoring and enhancing mental and physical health, occupational therapists are in a position to break the preoccupation with reducing the incidence of ill health and become equally involved in providing programmes that cause good health and well being.

Postcard #4: "Hold my hand I'm dying."

In my early days at the University of the Orange Free State, most of my "clinical" work involved working with people who were comatose and in the intensive care unit (ICU). My hypothesis was that applying various forms of sensory stimuli, such as taped music; voices of loved ones, tactile stroking/rubbing of limbs, pleasing olfactory stimuli such as mint and rose waved gently below the nose, would assist in the awakening-out-of-coma-process. On one of these occasions only a nursing sister and I were in the ICU and there were only two "patients": mine, a young man recovering from a head injury and the second, a middle-aged lady who had had a stroke the night before. She was dying and the sister was on the telephone trying to call her family to get them to her bedside before she died.

In the process of working this sensory therapy upon my patient I noticed the middle-aged lady suddenly begin to struggle, tossing her head from side to side, thrashing with the sound side of her body and emitting a deep-down-dying-groan, almost inaudible, from her throat.

"I am trying to get the daughter of Mrs XXX, please can you tell her it's Sister YYY from the ICU at ZZZ Hospital, I need to speak to her urgently concerning her mother!"

*An irresistible magnet pulled me away from my "patient", towards the bedside of this precipitously-clinging-to-life mother, I took her wrist in my left hand and, circumscribing it with mine, found her pulse with my index and mid-finger tips; with the other hand I gently stroked her head. I can't remember whether I spoke to her or not ... all I remember was that she immediately stopped struggling, became calm and the pulse beneath my fingers went **lub-dub-lub-dub-lub-lub-lub-dub-dub-lub**.....*

*I like to think it was not coincidental, but that I was able to provide some comfort in that possibly lonely and frightening transition between life and death, which helped to make that transition easier for her.
Bloemfontein (circa) 1978.*

What I am trying to convey in Postcard #4 is the unpredictability of working as an occupational therapist, the often unpreparedness of the therapist to deal with situations for which s/he is not necessarily trained. Our curriculum can never prepare us to deal

with the complexity and multiplicity of situations, like the one described, which we will encounter during our working life, but it must provide us with a resilience and a *savoir faire* that makes it possible to know what to do when these situations arise. It is a type of inner therapeutic intuition and caring that is there in all of us but must be nurtured to extreme levels in those of us who work daily with individuals who have experienced intense physical and psychological trauma/illness.

It is thus my belief and deep concern that the obsessive preoccupation of modern medicine with objectivity and accuracy, and its mechanisation of the human body, have underestimated and undermined the inner intuition and spirituality that all humans possess, and which is essential in the work that occupational therapists do and should therefore be nurtured and exploited in their training.

Kang (2003)¹ maintains that any one of occupational deprivation, dysfunction, imbalance or injustice² will lead to spiritual deprivation and the reversal of any one of these will lead to spiritual fulfilment. The realisation of the need to define and explore spirituality within the realms of occupational therapy and disability has become an important focus in current occupational therapy ideology. [McColl, 2000; Hammell, 2001; Luboshitzky and Gaber, 2001; Unruh *et al*, 2002; Kang, 2003 and Ramugondo, 2005.]

Why occupation is the central focus of occupational therapy

Defining occupation and activity

The first and only consensus paper on occupation published by the American Occupational Therapy Association (AOTA)³ defined occupation as '*the ordinary familiar*

¹ Kang, C. (2003). **A psycho-spiritual integration frame of reference for occupational therapy Part 1: Conceptual Foundations**. Australian Occupational Therapy Journal. Volume 50: 92-103.

² Occupational deprivation refers to a state in which for political, displacement or other socio-political restrictions, an individual or group of individuals are unable to engage in occupations that are meaningful in their lives. (Whiteford, G, 2000:200). Occupational dysfunction refers to a state in which the individuals cannot or can only partially perform everyday occupations due to physical or mental impairment. Occupational imbalance refers to a state in which the normal balance and spread of daily occupations is changed such that excessive time may be spent on a particular category of occupation such as work at the expense of another such as leisure occupations. Occupational injustice refers to a situation or society in which the recognition of and provision for the occupational needs of an individual or community are not recognised (Watson R, 2004:56)

³ Christiansen and Baum. (1997).

things that people do every day'. Clark *et al*⁴ define occupations as chunks of daily activity that could be named in the lexicon of a particular culture. The Canadian Association of Occupational Therapists⁵ defines occupation as '*activities or tasks which engage a person's resources of time and energy; specifically self care, productivity and leisure*'. By referring to it as *human* occupation, Kielhofner⁶ makes it clear that occupation is a human condition; he further defines it as '*the doing of work, play or activities of daily living within a temporal, physical and socio-cultural context, that characterises much of human life*'. Wilcock, (1998:22)⁷ qualifies the definition further by referring to it as '*purposeful human activity*'.

Yet another definition⁸ maintains that occupation refers to "*daily activities that reflect cultural values, provide structure to living, and meaning to individuals; these activities meet human needs for self care, enjoyment and participation in society*" (Crepeau *et al*, 2003:1031).

Pierce⁹ proposes perhaps the most comprehensive definition of occupation i.e. '*a specific individual's personally constructed, non-repeatable experience ... It is a subjective event in perceived temporal, spatial and socio-cultural conditions that are unique to that one-time occurrence. An occupation has a shape, a pace, a beginning and an ending, a shared or solitary aspect, a cultural meaning to the person, and an infinite number of perceived contextual qualities. A person interprets his or her occupations before, during and after they happen. Although an occupation can be observed, interpretation of meaning and emotional content of an occupation by anyone other than the person experiencing it is necessarily inexact*' (Pierce, 2001: 139¹⁰).

⁴ Clark, F.A. Parham, D. Carlson, M. Frank, G. Jackson, J. Pierce, D. Wolfe, R. & Zemke, R. (1991). **Occupational science: Academic innovation in the service of occupational therapy's future**. American Journal of Occupational Therapy. Volume 45. 300-310.

⁵ Canadian Association of Occupational Therapists. (1995). **Guidelines for the client-centred practice of occupational therapy**. CAOT, Toronto, Canada: 140.

⁶ Kielhofner, G. (2002). **Model of human occupation-theory and application** (3rd Edition): 1. Lippincott, Williams and Wilkens, Philadelphia.

⁷ Wilcock (1998):22-26

⁸ Crepeau, E. Cohn, E. & Boyt Schell, B. (2003). Glossary. In: Crepeau, E. Cohn E. & Boyt Schell, B. (2003).

⁹ Pierce, D. (2001). **Untangling occupation and activity**. American Journal of Occupational Therapy. Volume 55(2): 138-146.

Based on these definitions it is clear that involvement in occupation is an intensely complex and subjective experience influenced by many factors, including the meaning that a particular culture ascribes to it.

Defining Activity

Pierce¹⁰ defines activity as *'an idea that is held in the minds of persons and in their shared cultural language. An activity is a culturally defined and general class of human actions. The common sense meaning of activities, such as play or cooking, enable us to communicate about generalized categories of occupational experiences in a broad accessible way. An activity is not located in a fully existent temporal, spatial or socio-cultural context'* (Pierce, 2001: 139).

Pierce clarifies this by giving an example of eating as an activity concept which can conjure up a series of thoughts or ideas such as images and thoughts of food, socialising over a meal, cooking a meal, utensils used for a meal, types of food and so on. It is an idea, a thought that creates different mental representations for each individual but carries a shared understanding of eating as a culturally defined class of actions. It is not necessary to have done the activity to understand the cultural meaning; it is an objective experience. However, if one recalls an occupation such as eating breakfast this morning, it has clearly distinctive features and is fully situated within a real context. One can recall what was eaten, where it was eaten, with whom and so on. It has sights, sounds, tastes and textures and a specific meaning within one's unique life. It is a subjective experience.

Evans¹¹ proposed that occupation is the active or doing process of performing a goal-directed, intrinsically gratifying and culturally appropriate activity. But Christensen and Baum¹² critique this by drawing our attention to the fact that the concept extends beyond the active or doing process in occupation: for example, sitting under a tree and meditating may require little physical activity other than breathing. In addition one could question how intrinsically gratifying it may be to clean a dirty toilet. They expand further

¹⁰ *ibid*: 139

¹¹ Evans, A. (1987). **Nationally speaking: Definition of occupation as the core concept of occupational therapy.** American Journal of Occupational Therapy Volume 41: 627-628.

¹² Christiansen and Baum (1997): 5

in distinguishing between occupation and activity by maintaining that while all occupation is purposeful, not all purposeful activity is occupation. For example, placing the lid on a jar of jam is a purposeful activity but could it be defined as purposeful occupation? In contrast, making a sandwich (of which replacing the lid of a jam jar may be a part) has group and individual meaning and would qualify as occupation in most definitions. Crepeau¹³ suggests that tasks and activities are nested within the broader category of occupations. Wilcock¹⁴, helped by the Oxford English Dictionary, defines activity as *'the state of being active; the exertion of energy, action and, like occupation, describes specific deeds or actions. It is often used interchangeably by occupational therapists, but activity is seldom used to imply paid employment'*.

For the purpose of this thesis it is important to highlight several significant facts related to these definitions.

Firstly, they have been compiled by white occupational therapists working in mostly Western, so-called 'developed' countries. And while they allude to the importance of considering socio-cultural contexts and meaning of activity and occupation for different cultures, the basis of these definitions is rooted within a Western framework and thus might quite possibly exclude aspects of human occupation that could be of significance to cultures other than Western ones. This will be discussed in more detail in Chapter 7.

Secondly, there are common characteristics of occupation discussed or alluded to within most of these definitions that have particular relevance to South African occupational therapy. These are:

- Occupation includes those purposeful activities that humans carry out every day and throughout the day. The question here arises as to what one defines as purposeful. What may be purposeful to one is not necessarily purposeful to another. For example, a feeding mother who sprays milk from her breast over the smouldering ashes of a home that has been burnt to the ground by lightning¹⁵.

¹³ Crepeau E.B. Analyzing occupation and activity: A way of thinking about occupational performance. In: Crepeau, E.B, Cohn E.S and Boyt Schell B (Editors). (2003).

¹⁴ Wilcock (1998): 24-25

¹⁵ This incident was witnessed by me as a little girl of about 8 years old, when my brother, some friends and I went to observe the razed-to-the-ground homestead of a Swazi family who lived

- Occupations have a definite temporal component both in terms of approximate duration, as well as time of the day or night when they are performed. How do these differ from culture to culture? How does the time I take to cook a meal on an electric stove differ from the routine and time taken by someone who cooks a meal over an open fire? During the season of Ramadan¹⁶, Muslim families eat their meals only between sunset and sunrise; breakfast at 3 or 4 o'clock in the morning would not be considered appropriate for other cultures.
- Occupation requires both physical and mental effort/energy.
- Occupations have social, cultural and contextual significance for the performer.
- Occupation includes work, personal care, leisure and social activities of daily living. What other categories may exist which other cultures might include here, for example spiritual activities or activities related to rituals, that the Western classification of occupations does not include or classifies in a different way?

In the past South African occupational therapists have done very little research and published very little on the relevance of human occupation to the various ethnic African cultures and Asian cultures that have become part of the South African community. Nor have we adequately explored how past and existing socio-political and socio-economic factors and context have negatively impacted upon the satisfactory engagement of many South Africans in meaningful occupations that contribute to their health status.

However there has been a recent upsurge in research and publications by progressive thinkers in occupational therapy, including South African occupational therapists, who have produced provocative evidence of and argument for the urgent need for occupational therapists to be far more rigorous about knowing, understanding and respecting the variations and complexity of occupation within cultural diversity.

[Iwama, 2003, 2004, 2005a, 2005b; Fujimoto and Iwama, 2005; Watson and Swartz, 2004; Lorenzo, 2004; Galvaan, 2004; Algado, 2005; Awaad 2005; Bomfin, 2005; Duncan *et al*, 2005; Kramer–Roy, 2005; Kronenberg *et al*, 2005b; Odawara, 2005 and Ramugondo, 2005.]

close to us, which had been struck by lightening and in which the 2 or 3 child occupants had been burnt to death.

¹⁶ Ramadan is the ninth month of the Muslim year, spent in fasting from sunrise to sunset.

Current South African curricula in Occupational Therapy base their classification of occupational activities upon Western categories. Broadly, these are: work activities, leisure activities, personal care activities and social activities. Does this classification concur with those of African or Indian cultures? Or are there other categories/sub-categories of activity that these cultures would include or exclude? What specific activities are gender-based, or have specific significance or taboos for certain people?

Human occupation: central to life, health and well being?

In his book on wartime therapy written in 1919, William Rush Dunton maintained that *'occupation is as necessary to life as food and drink. That every human being should have both physical and mental occupation... That sick minds, sick bodies, sick souls may be healed through occupation'* (Crepeau et al)¹⁷. From the moment we leave the womb, our little bodies move through a miraculously planned process of preparing them to participate in the multiple activities that will not only make it possible for us to survive but will provide us with the ability to enjoy our existence, interact with others and give meaning to our lives through doing things and being and becoming our unique selves.

So the neuromuscular and skeletal system, together with the psyche and soul within us, become fine tuned to deal with something as mundane as washing our hands or something as intricate and complicated as the surgical reattachment of a severed hand onto its mother-limb. From the simple act of walking to the complex circus and gymnastic feats of the body that we see on television; from dealing with the rebuke of an angry mother to dealing with the death of a child; whatever the situation or circumstance, each requires some or other occupational 'doing'.

Wilcock¹⁸, in her reflections upon doing, being and becoming, suggests that doing and being are central to healthy living, and that becoming whatever a person is best fitted to become is dependent on both doing and being. She further maintains that the medical model view of disorder has had a very constraining influence upon the profession of occupational therapy because the language of this model focuses on the negative and problematic aspects of illness and disability rather than on the positive relationship between occupation and health, and that occupation is the natural biological mechanism

¹⁷ Larson, E. Wood, W. & Clark, F. Occupational science: Building the science and practice of occupation through an academic discipline. In: Crepeau, E. Cohn E. & Boyt Schell, B. (2003).

¹⁸ Wilcock, A. (1999).

for health. She thus suggests that occupational therapists should break down the barriers that have constrained our understanding of the potential and importance of occupational therapy not only to illness and impairment but also to health and well being. This concept is central to a progressive attainment of our potential as a profession.

Considering the centrality of occupation to humans and to the holistic and all-encompassing ethos of occupational therapy, it is imperative that occupational therapists have a thorough understanding of human occupation and how it is classified, interpreted, signified and enacted by the various cultures with which the therapist may interact within her/his daily work. Hence, it is absolutely essential in a multicultural society such as South Africa that occupational therapists have an adequate understanding of and respect for the differences that human occupation may represent for the various cultures that we serve and interact with. Inadequate understanding of and respect for human occupation within a specific cultural context is likely to create a situation that is contrary to being uplifting and therapeutic.

Iwama¹⁹ suggests that while occupational therapy today has developed into an international movement that endeavours to benefit individuals and societies by focussing on the important dynamic between occupation and well-being, we have not fully considered whether the rest of the world (other than the Western and European countries) shares values about what constitutes well-being and the centrality of meaningful action to it. He maintains that there is “*a dearth of critical reflection on the universality of these and other core tenets of occupational therapy*” (Iwama, 2003:582). Iwama (2003:583) further refers to those who reside ‘*outside of common Western experience*’ and how they may find occupation to be problematically ethnocentric. There is, for example, no corresponding concept in the Japanese language that captures the contextual meaning Westerners ascribe to occupation and its link to well-being and health.

Thus it is that the common occupational therapy discourse constructed, as it were, around Western values and concepts, continues uncontested and this has imbued occupation with a universal quality and meaning which is able to transcend cultural

¹⁹ Iwama, M. (2003). **Towards culturally relevant epistemologies in occupational therapy.** American Journal of Occupational Therapy. Volume 57(5): 582-588.

boundaries of meaning²⁰. As a profession that espouses being sensitive and caring to the needs of those we serve, we need to ask ourselves, in South Africa, if we have really listened to the previously silenced voices of those we serve, and their views on the meaning of occupation and its link to well being and health.

The face and nature of human occupation changes almost daily, not only from country to country but also from culture to culture, and because cultures are not homogenous there are changes within cultures as well. The modern world is rapidly becoming more and more mechanised, thousands of refugees become displaced daily through natural or political upheavals. If it is not the devastation of years of hot, relentless and prolonged drought in parts of Africa, it is the horrific consequences of natural disasters such as the tsunamis to many of South East Asian coastal countries, or the political disruption caused by the wars in areas such as the Middle East, Zimbabwe, DRC and the Sudan. These catastrophes often result in joblessness and encampment in ghettos for extended periods. The impact of this results in what Whiteford²¹ refers to as *occupational deprivation*, which is a term used to describe a state in which people are precluded from opportunities to engage in meaningful occupation due to factors beyond their control.

Engagement in occupation may result in a variety of intensely biopsychosocial and spiritual experiences. The physical and psychological benefits of swimming a few hundred metres a day, or running around the block have long since been scientifically proven. The pleasures of cooking a meal and sharing it with friends, or the spiritual joy of crunching the loamy soil under one's fingers while planting seeds, and watching with delight as they emerge in green minuteness from their dark loamy womb some days later, are a few examples of the countless forms of occupation and its effects upon holistic wellness and health.

There is no doubt that daily involvement in a variety of occupations is universal to human beings regardless of their culture, that some occupations afford one pleasure and enjoyment as others do not. That some are essential to survival as others are not is also an occupational universal. But it is the emphasis, meaning and significance that we give

²⁰ Ibid: 583

²¹ Whiteford, G. (2000): **Occupational deprivation, global change in the new millennium.**

to various occupations that differ across cultures. Our ability to truly use occupation as a means of promoting health and wellness will be determined by a recognition and comprehension of such differences.

An understanding of the variety of belief systems that are linked to illness and health that are particularly relevant amongst the indigenous ethnic groups within our country, as well as the large number of South Africans with Asian origins, and which differ from Western belief systems, is necessary. This is particularly important when working with individuals with mental health problems. Beliefs and values linked to occupation, health and disability also carry economic implications. According to Charlton²² the political-economic and socio-cultural aspects of disability oppression will determine the form of resistance towards those affected and who is affected by it. For many people with disabilities, their condition tends to be synonymous with joblessness and concomitant poverty.

This situation also needs to be viewed in the light of the broader economic and geopolitical context. Oyèwùmi²³ says that the global historical processes that have impacted upon Africa i.e. the slave trade, colonization (and in our case also apartheid) have resulted in Africa becoming politically, economically and culturally dependent upon Western Europe and North America. As a result Africa has become the recipient of ideas and goods of dubious and often harmful value. In order to transform the degradation and dependency that this has brought upon Africans today, she says, Africans need to be cognizant of the enduring effects of their history and the many forms of oppression from which they still suffer.

For example, apartheid resulted in a phenomenon which Kronenberg and Pollard²⁴ refer to as *occupational apartheid*, which is based on the premise that some people have a different economic or social value and status to others and thus become marginalised and are denied the right of access to participation in occupations that they value as being of meaning and use to them. The result of this was that most South Africans, other

²² Charlton, D. (1998). **Nothing About us Without us: Disability Oppression and Empowerment.** University of California Press. Berkley.

²³ Oyèrónké, Oyèrónké. Introduction: Feminism, sisterhood and other foreign relations. In: Oyèwùmi, Oyèrónké. (Editor). (2003).

²⁴ Kronenberg F & Pollard N. Overcoming occupational apartheid – A preliminary exploration of the political nature of occupational therapy. In: Kronenberg, F. Algado, S. & Pollard, N. (Editors) (2005).

than whites, had little if any access to most occupations that were considered to have status or large incomes, such as law and medicine. Similarly, Turner²⁵ refers to how professionalisation is regarded as an occupational strategy in which social groups attempt to control their place within the market.

Feminist and Critical Perspectives on the Marginalisation of Occupational Therapy in the Early Years

Gendered occupational apartheid

When occupational therapy was conceived by Dr Raymond Dart and some of his female medical doctor protégées in South Africa in the early 1940's²⁶, it was a time when there was what I will refer to as gendered occupational apartheid in which European men and women were assigned distinct roles and certain occupations were considered to be the domain of women while others were considered the territory of men.

Authority, political and occupational leadership were still very much the domain of men while women were mostly assigned to childbearing and housekeeping. Certainly, women's involvement in professional occupations was not common and those women who did venture into professional life were usually consigned to fields that men felt were more "feminine", such as those which required caring for the sick and disabled (for example, nursing and occupational therapy).

This pattern of gendered power relations and gendered occupational identity emerges also in the processes of knowledge production. The history of nursing was written by men and, as such, men decided upon what might or might not be transmitted. Thus men were able to define nurses' roles, first as women, then as nurses, according to the dictates of their patriarchal views on the structure of society²⁷. Women thus received the knowledge that men thought they should have.

To a large extent the history of occupational therapy parallels that of nursing in this regard albeit not over such an extended period of time. As women have different ways

²⁵ Turner, B.S. and Samson, C. Professions Knowledge and Power. In: Turner, B.S. and Samson, C. (Editors). (1996).

²⁶ Dart, R.A. (1963). **The Initiation of Occupational Therapy in South Africa**. South African Journal of Occupational Therapy. Volume 1(8):4-6.

²⁷ Hunt, J. (1998). Feminism and Nursing.

<http://www.clininfo.health.nsw.gov.au/hospolic/stvincents/stvin98/a5.html>.

of knowing, they are not homogenous and their worldview is influenced by their history and differences such as social class and ethnicity²⁸. In addition, economic and political factors will affect their values, beliefs and experience. Since the role of women in contributing their own knowledges was so circumscribed by male authority it is not only conceivable, but also probable, that the founding knowledge base for occupational therapy in South Africa was homogenised, as for nursing, into one that clearly defined the role of the profession as being supportive, geared towards providing backup and technical service to the medical doctors who conceived of OT.

An important function of medical dominance is to preserve and extend the medical access to its clientele by limiting and subordinating adjacent occupations²⁹. This can be seen in the history of occupational therapy and in the constitution and operations of doctor-controlled structures such as the South African Medical and Dental Council, in which the medical profession has utilised a variety of strategies to successfully maintain its position within the class structure and professional hierarchy over the last 100 years. This professional dominance of doctors is clearly grounded in the possession of a body of knowledge, which becomes the crucial feature in their exercise of professional power³⁰.

Turner³¹ makes use of the term 'subordination', which he describes as a mode of domination and defines as being "*a situation in which the character and activities of an occupation are delegated by doctors with the result that there is little scope for independence, autonomy and self regulation*" (Turner, 1996:152). The clear history of subordination of occupational therapy in South Africa has significantly affected the independence, autonomy and self-regulation of the profession; perhaps this is why many occupational therapists experience difficulty in clearly articulating our role and identity.

For the past three thousand years the belief system of patriarchy, in which all things male are revered and reality is divided into *feminine* and *masculine*, has dominated most of women's experience. This definition of things in terms of binary structures is typical of

²⁸ Ibid: 2

²⁹ Turner, B (1996): 152

³⁰ Ibid: 151

³¹ Ibid: 138

the Western world.³² A strange paradox has occurred in occupational therapy. Historically the original role models for occupational therapists were medical men and Kelly³³ (1996) maintains that the socialisation of the mostly female oriented profession by these medical male role models, and the need to be accepted by the medical profession, resulted in them losing the integral feminine parts of themselves, abandoning their original holistic perspective³⁴ and consequently dismissing the female principles of intuitivism, holism and subjectivity in favour of the masculine principle of scientificism, reductionism and objectivity.

This trajectory has relevance to the entire development of occupational therapy in this country, but specifically to the early days of training of occupational therapists in historically black universities. Knowledge situated within this dominant paradigm must reflect through the attitudes, practices and values of those who exercise it. But because this *androcentrally* framed epistemology has been situated within a *gynocentrally oriented* profession³⁵, its interpretation and enactment have largely skewed this epistemic authority to represent the interests, emotions, attitudes and values of a predominantly European, upper middle-class, Judeo-Christian female.

Emotions, attitudes, interests and values are gendered. *Androcentrism* defines the way men are depicted in terms of their interests, emotions, attitudes and values. These are mostly determined by social roles designated as being specifically appropriate to men, while the same applies to the converse, *gynocentrism* i.e. those interests, emotions, attitudes and values appropriate to women. In addition to this, some skills may be labelled masculine or feminine. Thus a skill such as caring for children has become labelled as a woman's skill as opposed to the skill, for example, of whipping up determination in rugby players, which would be labelled a man's skill. Such attitudes and interests structure the cognition of their possessors³⁶.

³² Kelly, G. (1996) **Feminist or feminism? The feminine perspective in occupational therapy.** British Journal of Occupational Therapy. Volume 59(1).

³³ Ibid:3

³⁴ Ibid: 3

³⁵ Andersen, E. (2003). **Feminist Epistemology and Philosophy of Science.** Stanford Encyclopaedia of Philosophy. <http://plato.stanford.edu/entries/feminism-epistemology>.

³⁶ Ibid:5

The perception of women is deeply entrenched and in Western culture where occupational therapy's origins are rooted: women are 'naturally' expected to put the needs of others before their own. They are carers of children, their spouses and the elderly³⁷. Occupational therapy in South Africa was born into this prevailing attitude, and it contributed to the marginalisation and undermining of our epistemic authority. Thus, by virtue of the conditions of its origins in South Africa, occupational therapy was at its conception relegated to an inferior status by those who conceived of it.

Evidence of this attitude is reflected in the following statements by, firstly, Prof Raymond Dart (1963:4)³⁸ our founding father, who, when talking about what skills occupational therapists can bring to their patients, says that the predominantly female occupational therapists should not ape men but rather bring *'into their professions the gifts, skills and attitudes with which **women alone** could leaven and equilibrate them (the patients) and thus render them truly human'*. And in his foreword to the August 1957 South African Journal of Occupational Therapy, the President of the SAAOT, Dr Kenneth Mills (1957:2)³⁹, alludes to this gynocentrically designated social role when he says: *'After all, even those Occupational Therapists who have exchanged the practice of their profession for the honourable calling of wife and mother (1) must be aware of the truth of the old saying: "Satan finds some mischief still (2) for idle hands (3) to do" and must therefore find the application of the principles they learnt (4) as Occupational Therapists of value in the management of their own homes and children.'*

[Mills' suggestion that those called to being wives and mothers (1) should have need to occupy their idle hands (3) is typical of the patronising male attitude of those days that the work of wife and mother was actually a state of idleness, which tacitly implied that the work of men was business. This patronising attitude is further encapsulated in his suggestion that women would apparently get up to mischief (2) if they were left with nothing to do and should therefore apply the principles learnt in occupational therapy (4) as a preventative measure.]

Implicit in this attitude is the belief in a disparity between women's and men's way of thinking and knowing and hence, by virtue of the its relegation to the lower echelons of

³⁷ Ribbens, J. & Edwards, R. (1998). **Feminist Dilemmas in Qualitative Research**. Sage Publishers. London.

³⁸ Dart R (1963):4-5

³⁹ Mills, K. (1957). **Foreword to the journal of the South African Association of Occupational Therapists**. South African Journal of Occupational Therapy. Volume 1(8):2.

the professional hierarchy at the time, the devaluation of this knowledge. It is also possible that because occupational therapy was acknowledged as a 'female' profession from its birth and females were assigned to inferior and oppressed roles, occupational therapists have internalised the ascribed 'inferiority'.

The extent to which a skill is perceived by others as the proper province of a particular gender, in this case occupational therapy as a female profession also determines the degree to which others may grant or withhold acknowledgement of the agent's expertise⁴⁰ within it. This, and the equally poor salaries paid to occupational therapists of both genders, contributed further to keeping males out of the profession which in turn reinforced the perception of occupational therapy as being an almost exclusively female profession.

The evidence of how occupational therapists tolerated this hegemony from the SAMDC, the Government in power and the doctors "under" whom they worked in the early days has been revealed in Chapter 4, and displays not only a complacency but a naivety on the part of our pioneer occupational therapists towards their right to take ownership of their own knowledge and hence establish their own epistemic authority. This behaviour is also reflective of the inferiority complex that the situation perpetuated. In order to substantiate this claim regarding the entrenchment of inferiority through marginalisation I will present some examples below.

The Broom-cupboard Syndrome: a further reflection on our status and marginalisation

Throughout history in most countries, occupational therapy and rehabilitation have frequently been allotted the dregs of any budget or space where they are part of a service. Over the years OT professionals have become adept at recycling splinting materials, making articles from waste products or simply cutting back, and grown accustomed to working in broom-cupboard type departments situated somewhere in the dark bowel of a hospital. I have a colleague who works in a large rehabilitation section of a well-known hospital in Gauteng, who has produced a booklet on how to make the most amazing articles out of waste materials. This is partly because her annual budget for materials is perpetually so meagre that she has had to learn to make do with using waste

⁴⁰Hunt, J. (1998): 3

materials such as rubber and leather off-cuts, and has become adept at tracking these down in industry. These examples are not new to therapists in South Africa - many, I am sure, can relate similar tales.

In the early 1970's when I was assisting in developing occupational therapy services in the Durban metropolis, after months of negotiations and pleading with the medical superintendents at two of the hospitals where new services were needed, in both these hospitals I was condescendingly allocated dirty old storerooms far from the wards and hubbub of the hospital. The fact that, without conferring, the superintendents at both these hospitals allocated such second-rate accommodation for occupational therapy provides an interesting insight into the level of esteem in which occupational therapy was held at the time. One of these rooms had no windows but a double door that had to be kept open, rain or shine, to ensure adequate air circulation. The other was situated in the nurses' home very distant from the main hospital and had also previously been used as a storeroom. The hospital was in an industrial area with high levels of smog and dirt, hence, every time I arrived for my weekly clinic I would have to spend the first half hour wiping a thick layer of grime off the surfaces of chairs and tables, before commencing therapy.

Not surprisingly, these new services were not assigned a porter. I was sometimes able to enlist the help of the physiotherapy porter but, for the most part, had to fetch and carry the individuals referred for occupational therapy the long distances to and from the wards, wasting valuable therapy time doing so. After all the months of negotiations to try and obtain space for a department, I accepted these squalid conditions and my porter duties without question, being only too delighted at having quarters in which to start assisting the many disabled people in these hospitals who, until then, had not had access to occupational therapy. It would be interesting to see how current labour laws and unions would deal with such a situation were it to arise today!

While this lack of prodigality may sound laudable, it is actually more laughable because, as Wilcock⁴¹ puts it, in times of economic pressure the most prestigious health services reflect the dominance of materialistic values and are those that are most technologically advanced and expensive, such as medicine. This privileging of the new and expensive

⁴¹ Wilcock, A. Occupational therapy's relationship with occupation and health. In: Wilcock, A. (Editor). (1998).

has also contributed to retrenchments and reductions in occupational therapy services before other services.

The power of empiricism and its effects upon the identity of occupational therapy

Additional factors that have lead to the marginalisation of occupational therapy as a profession revolve around the dominance within the medical milieu of empiricism with its inherent demand for evidence of effective practice. Adjunct to this is the dearth of adequate research produced by occupational therapists to substantiate the value of their work. Early publications in the South African Journal of Occupational Therapy are mostly what could best be described as a form of action research based upon experiential descriptions of practice by various authors within the various fields of occupational therapy. Very few of these articles portray evidence of the use of the empirical research, which is classified by the Western world as “*best evidence*” on their hierarchy of research evidence.

Today most occupational therapists in Western countries consider the production of research evidence to back up good practice as being an imperative and are following in the footsteps of their medical patriarchs in making evidence-based practice (EBP) their mandate for this millennium⁴².

EBP is basically defined as the integration of individual clinical expertise in making conscientious, explicit and judicious use of current best evidence when making decisions about the care and treatment of individual patients⁴³. Evidence in this context generally means evidence that is synonymous with research. The research evidence that one uses should be evaluated against a hierarchy to establish where it falls on a continuum of best evidence to worst evidence. Obviously we should, for the most, part try to make use of only the best evidence. Holm (2000)⁴⁴ describes five hierarchical levels as follows:

⁴² Sackett, D. Rosenberg, W. Gray, J. Haynes R & Richardson, W. (1996). Evidence-based medicine: What it is and what it isn't. *British Medical Journal*, 312.71-72.

Holm, M. (2000). **Our Mandate for the New Millennium: Evidence Based Practice**. Eleanor Clark Slagle lecture. *American Journal of Occupational Therapy*. Volume 54(6): 575-585.

⁴³ Holm, M. (2000). **Our Mandate for the New Millennium: Evidence Based Practice**. Eleanor Clark Slagle lecture. *American Journal of Occupational Therapy*. Volume 54(6): 575-585.

⁴⁴ Ibid

TABLE 6: HIERARCHICAL LEVELS OF RESEARCH EVIDENCE FOR EVIDENCE-BASED PRACTICE

Level	Design	Type of evidence	Approach
Level I	Systematic review and meta-analytic study	Strongest levels on hierarchy, based on very rigorous methodology. ↓ Lowest level on the hierarchy	Quantitative
Level II	Randomised control studies		
Level III	Trials without randomisation		
Level IV	Non-experimental studies		
Level V	Opinions of respected authorities		Qualitative

(Adapted from Margo Holm (2000) based on Hierarchy by Moore et al⁴⁵.)

As can be seen from this table, the highest level of evidence is that based upon those that follow quantitative designs and at the lowest level on the hierarchy are the qualitative designs⁴⁶. In the first half of its history SAJOT published articles that mostly fell under level V of this hierarchy. Today, although the number of articles using empirical research has improved, the volume is still not on a par with medical research or the level I to level III research that our colleagues in USA, Australia, Canada, New Zealand and the United Kingdom are producing. Rappolt (2003)⁴⁷ maintains that the shortage of creditable research is one of four main limitations to EBP. She also maintains that there is, to date, very little research evidence to support the fact that EBP actually works, and that *“implicit in the promotion of evidence-based practice is the notion that high quality evidence is available to address each clinical question”* (Rappolt, 2003:589).

⁴⁵ Moore, A. McQuay, H. & Gray J. (1995). Evidence based everything. *Bandolier*. Volume 1(12):1

⁴⁶ Joubert, R.W.E. (2005). **Evidence-based practice: A critique based on occupational therapy within the South African context**. *South African Journal of Occupational Therapy*. September, Volume 35 (2): 8 – 13.

⁴⁷ Rappolt, S. (2003). **The role of professional expertise in evidence-based occupational therapy**. *American Journal of Occupational Therapy*. Volume 57(5): 589-593.

Cusick (2001)⁴⁸ maintains this present emphasis on quantitative research in EBP could well influence what we become as a profession in the future. It is fairly obvious that the concept of EPB is rooted, and thrives, in the positivistic and very reductionistic medical model orientation in which quantitative research has sovereignty over qualitative research.

It is difficult to imagine how therapists in this country are currently expected to produce sufficient appropriate evidence that is relevant to our diverse, multicultural population, taking into account the following factors within the South African context with its first/third world dichotomy: a health service which is comparatively under-resourced in terms of rehabilitation personnel; the majority of our people having a language and cultural composition entirely different to the West in which EBP was spawned; lack of access to telecommunication services such as the internet in some rural areas, and the existing paucity of quantitative research in occupational therapy.

Regardless of what one's own particular views are regarding the quantitative versus qualitative debate, the fact that the evidence expected in current day EBP is so entrenched within the positivist paradigm immediately situates South African occupational therapy at the outer margins of acceptable evidence practices because a substantial proportion of articles appearing in our South African Journal of Occupational Therapy do not fall within the levels I and II of the hierarchy described in table 4 above. This thesis thus poses the question: which, and whose, rationality is closest to the truth – the scientific rationality or the non-scientific rationality? Each has its place, but which reveals the most explicit truth under particular circumstances, especially when one seeks that truth deep within the core of humanity's existence? How can one be deemed superior to the other?

Occupation and Wellness

The complex inter-relationships between occupation and health and wellness are enormous. Involvement in occupation is an integral part of human existence and survival

⁴⁸ Cusick, A. (2001). **OZ OT EBP 21: Australian occupational therapy and the 21st Century.** The 2001 Sylvia Docker Lecture: The Australian Occupational Therapy Journal. Volume 48:102-117.

regardless of race, gender, culture and age. That this involvement produces a variety of both beneficial and detrimental effects is also true. It is the occupational therapist's role to harness those beneficial effects and use them to enhance health and wellness. Or it is to make it possible for people with disabilities to regain independence in being able to perform meaningful occupations again, to return dignity, value and quality of life to those who would otherwise be dependent on others. It is also the occupational therapist's role to identify those aspects of, or surrounding, human occupation that may be detrimental to health and to provide ways of overcoming these.

In her now famous article '*Reflections on doing, being and becoming*', Ann Wilcock⁴⁹ maintains that the doing, which is synonymous with occupation, is intrinsically linked with being or that transient moment in which one experiences oneself absorbed in the doing and thus also in a type of self-discovery; that the balance between the doing and being is central to healthy living, and finally, that the becoming whatever one is best fitted to become is dependent on both doing and being. It is this specific dynamic that provides the foundation for the relationship between occupation and health. If the ability to do is lost through some physical, mental or circumstantial cause, then the ability to be and become is also lost and hence the cycle of forces that contribute to one's health and wellness is broken, resulting in illness and ill health.

These are universal concepts that are generic to all cultures and thus universalise the basic principles which underlie occupational therapy. But it is the hegemony of the Western–Eurocentric-American bias in the ideas and knowledge base upon which current occupational therapy theory exists that makes it inadequate, partially inappropriate and even inaccessible to the millions of other people who might benefit from it had we included their world views in this epistemology.

Further evidence of flaws in the South African Occupational Therapy epistemology will be revealed in the following chapter.

⁴⁹ Wilcock, A. Introduction. In: Wilcock, A. (Editor) (1998).

CHAPTER SIX

Models of Dissatisfaction: Those we serve, do we serve them right?

Route Map: This chapter will continue with an exploration of how historical influences impacted negatively upon the epistemology of occupational therapy in South Africa. It will particularly focus upon the position of people with disabilities and the absence of their role in contributing to the epistemology. It will examine attitudinal influences of the period in question towards people with disabilities and suggest how this reverberated upon occupational therapy services. It will substantiate the argument by providing literary support, a speculative analysis¹ of an interview with a person with disabilities, and historical documentation reflecting the situation of people with disabilities during the apartheid years of OT's development. It will briefly suggest influences more appropriate to the OT epistemology.

Letter #2: K'hulu's Story

Every Thursday morning during the academic term I join a multidisciplinary group of students at the Amaroela² first aid centre in the beautiful Acacia Valley. This fieldwork affords the students a service learning experience in a semi-rural setting, during which they work in partnership with the mothers or caregivers of children with disabilities, the children themselves and community health workers. Although it is tarred, the route to the first aid station is an extremely steep and treacherously winding road of approximately 6 kilometres. I travel in my own car and the students travel by taxi-bus.

On several occasions during this trip I passed a most extraordinary sight: an obviously severely disabled man, pulling himself up this steep, winding and treacherous road by his hands while sitting on a skateboard! The students also informed me that they had seen him before, begging in a shopping mall in the suburb of Industria², some 20 kilometres away.

Wanting to investigate further I phoned Siphos, a community rehabilitation facilitator in this area, who set up an interview for me with the man in question. So one hot and humid, midsummer morning, when the African sun is close to its hottest, Siphos and I parked our vehicles halfway up the steep and treacherous tarred road and continued on foot down some 300 meters of very steep, winding and slippery gravel pathway. On the way we passed several homesteads, typical of the area, some traditional mud, wood and thatched rondavels, others a variety of umjondolo type homes.³ Each had

¹ Speculative analysis: is a term coined to describe how original data is used to speculate a 'what if' outcome given the existing circumstances and speculation upon imposed circumstances; it is especially useful when there is a significant historical past.

² Fictitious names have been used for places and people to protect the identity of persons involved

³ Rondavel refers to traditional round tribal huts with conical roofs and umjondolo is the vernacular given to houses built in informal settlements which are often creatively built using whatever materials are available, they are however vulnerable to bad weather and are a sign of extreme poverty.

its human residents who waved and greeted us as we passed, and the usual contingent of skinny, aggressive dogs, clucking hens and gregarious goats nibbling at the surrounding vegetation.

Finally we reached the last homestead at the end of this path and upon enquiry, a middle aged lady pointed to a corrugated iron house not much bigger than a Great Dane's kennel. Arriving at the open door of this home, we were greeted by a middle-aged man with a very friendly smile framed in an extremely decayed set of teeth. His name is Khulu, the Zulu name for big or large.

There was a single bed with a dilapidated mattress upon which he lay, a ragged blanket covering his legs and a small cupboard next to the bed. The sun beat down relentlessly upon the tin walls and roof – the stifling heat was overwhelming.

Khulu was born in the district in approximately 1966 making him around 38 years old. When he was a small boy his parents sent him to Umkomaas to assist in looking after the cattle of a man who lived there. This man was not a relative of the family but it appears the family were poor and in this way the owner of the cattle possibly provided food for the mouth they could not feed. Khulu never went to school, and when he was approximately 9 or 10 years old, his problem started.

[Comment 1: During the interview I visually tried to establish the extent of Khulu's impairments. Severely atrophied leg muscles and plantar flexion contractures, legs also heavily scarred, which he informed me were the result of being run over on two occasions by cars while trying to cross the street on his skateboard. His right arm appears normal with strong and sinuous muscles, but both hands are wasted and contracted with little if any prehensile function in them. His left arm is also atrophied although the few muscles that work in it have been exercised to a very fine and tough tune. He says he has sensation in his lower limbs. My diagnosis: Tetraplegia⁴ of unknown origin, possibly polio. **See speculation 2 below.**]

The cause of his impairments, he informed us, was witchcraft⁵. There was no illness or accident. He tells a rather confusing tale about a fight he had with some young boys and a bantam bakŋje⁶ and that

it was after this that he became paralysed, implying that the boys had obtained the services of an uMthakathi⁷.

He was sent to hospital where he appears to have had some physiotherapy. Upon discharge he never saw his parents again and went to live with his brother and sister-in-law. She is a friendly and caring

⁴ Tetraplegia refers to the paralysis or paresis of three out of four limbs.

⁵ Known as 'umthakathi', this was probably a form of 'day sorcery' which occurs in situations rife with competition and rivalry in which a sorcerer is consulted who then administers various noxious potions, known as 'ukudlise', which are added to the victim's food or harmful substances are placed along the victim's path. (Ngubane, H. Sorcery (*Ubuthakathi*). In: Ngubane, H. (1977).

⁶ South African vernacular for a small lorry. At this part of the story the interpreter stopped and suggested that Khulu may not be mentally 'all there' because what he was saying did not make sense.

⁷ The *umthakathi* (sorcerer or wizard) is considered an enemy of society because s/he uses his/her powers for magic and antisocial reasons, [Krige, E.J. Medicine and magic. In: Krige, E.J (1965)] The Social System of the Zulus.

lady who joined us during the interview. She feeds him. She said he has a disability grant and sometimes he pays her. There was a tin plate with a half eaten sandwich on the cupboard next to his bed.

Apparently some years ago a man in Hilly village⁸ saw Khulu pulling himself along the road without any form of assistive device and gave him a skateboard, which was the beginning of a much more independent lifestyle.

His sister-in-law confirms that he gets himself, completely independently, up the winding path I described earlier, using his sound right arm and semi-paralysed left arm; he also pulls himself up the rest of the treacherous, tarred section of the road for about 3 kilometres until he reaches a tavern at the top where he catches a taxi-bus into Hilly village and from there to Industria² some 15 kilometres further. Once there, Khulu goes to the shopping mall where he begs. He spends anything from a week to two weeks living there where he has many friends and spends a lot of time socialising and having a good time. He sleeps in covered parking lots or alleys where he is protected from the rain and makes enough money from begging to buy food and drinks, which he shares with his friends. He smiled and laughed throughout this part of his story. He returns “home” periodically to rest himself for the next trip.

Finally, overcome by the heat, Siphio and I said our farewells and began the trek up the steep, winding and slippery gravel path to our vehicles. As I puffed and sweated up this difficult incline, using both my legs and occasionally, when I slipped, also my arms, I wondered in utter amazement how this intrepid man managed to traverse the same terrain with the type of impairments I had observed in my visual assessment of his limbs.



Scene typical of the environment where Khulu and Sam live

Photo: Margi Lilienfeld

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⁸ Fictitious name.

A Speculative analysis: What if?

There are several speculative questions that arise from Khulu's story which are relevant to this chapter.

- If he had received occupational therapy in the early 1970s when he became paralysed, assessment and subsequent interventions at the time might have prevented some of his contractures, but it is reasonably predictable that the conventional treatment of the day would have been applied i.e. provision of a wheelchair, possibly some splints for his hands and provision of an 'acceptable' income generating activity such as shoe repairing or leatherwork to do at home had his hand-function been improved. Worse still, he might even have been sent to an institution such as the Cheshire Homes.

Speculation 1: Would this not have robbed him of his current level of independence and control over his life and isolated him from the wonderful social opportunities and quality of life that his current existence provides?

- Knowledge of, and respect for, specific aspects of the African lifestyle, value systems and cosmology are essential components in assessing needs and bringing about meaningful rehabilitation to the many Khulu's we meet in our daily work.

Speculation 2: The researcher's own repudiation of Khulu's explanation of the cause of his current disability is clearly evident in her attempt to provide a scientific diagnosis (refer to Comment 1 page 109 above). The question arises as to how possible it is to provide deep and insightful support to someone if one does not clearly respect the individual's cosmology. This does not mean one has to believe in that cosmology, but simply understand and respect its significance to those who believe in it.

- Perhaps it is that very African worldview, unimpeded by the pessimism or cynicism of our Western views and values, that gave Khulu the extraordinary 'guts' and resilience to achieve what he has achieved today?

Speculation 3: *[After 30 years of working with African people who are experiencing the effects of disabling trauma and/or disease, I have also been particularly struck by a general character of stoicism, courage and resilience in the face of such adversity.]* I therefore speculate upon the possibility that some essential element in the African worldview and attitude provides a source of strength in times such as Khulu experiences, and argue that this needs to be better understood and exploited by those professions who are involved in the rehabilitation process following such trauma or illness.

- What competencies would we need to assess in a student who would have facilitated Khulu on his journey to where he is today?

Speculation 4: As suggested in Speculation 1: had Khulu been given conventional rehabilitation based upon the Eurocentrically, medical model oriented epistemology still influencing occupational therapy in South Africa, he would very probably never have achieved the quality of life he has today. One thus needs to ask, what needs to be added to our curriculum to ensure that our qualifying therapists can facilitate journeys such as Khulu's?

- Does begging constitute an occupation?

Speculation 5: Because of its origins within a middle class, European and a prescriptive medical model, occupational therapy possesses specific values around what constitutes acceptable occupations and lifestyles. The profession in South Africa and globally would have difficulty in doing vocational training for individuals who participate in some of the occupations that marginalized people may participate in, such as prostitution, begging, affiliation with gang culture and criminal occupations because they constitute unacceptable occupations and mostly are dangerous to one's health or the health of others. However, they exist and it is likely that they will continue to exist into eternity. Many of these occupations result from what Kronenberg⁹ describes as occupational apartheid (refer back to chapter 6

⁹ Kronenberg, F & Pollard N. Overcoming occupational apartheid – A preliminary exploration of the political nature of occupational therapy. In: Kronenberg, F. Algado, S. & Pollard, N. (Editors) (2005).

page 127) i.e. *‘the segregation of groups of people through the restriction or denial of access to dignified and meaningful participation in occupations of daily life on the basis of race, colour, disability, national origin, age, gender, sexual preference, religion, political beliefs, status in society or other characteristics’*. However when those with disabilities do become involved in socially ‘dubious’ occupations that help them to survive, such as begging or prostitution, our profession does not have an occupational perspective that includes these occupations within its repertoire.

One needs to speculate whether this self-selected and obviously successful occupation of Khulu’s, which he enjoys and which does no harm to him or any other, is better for him than one which may have been selected for him by an occupational therapist on the grounds of it being more socially acceptable. Given his lack of formal education and training, his physical limitations and the location of his home, the choices would be very limited and would probably be confined to some form of home industry such as shoe repairing or leather work. In turn the ability to learn the skill and market his product would be difficult even for the most educated person given his physical circumstances and context.

Those we serve, do we serve them right?

In a conference based on “Rethinking Care from the Perspectives of Disabled People” which was organized in 2001 by the Disability and Rehabilitation team of the World Health Organisation ¹⁰, the executive summary highlights the need to approach health and rehabilitation differently from the orthodox medical interventions and notions of care, which focus almost exclusively upon the perceived limitations of disability, rather than on society’s failure to accommodate these individual’s needs. Particularly alarming about the testimonials arising out of this conference from people with disabilities, apart from and in addition to the economic, political and social deprivations that they experienced, was that this situation was widely attributed to the inadequacy and ineffectiveness of the medical and rehabilitation services for the increasingly large proportion of the world’s population who are disabled.

¹⁰ WHO (2001) Note for the Press No16, 3 December 2001, International Day of Disabled Persons page 1-2

Charlton (1998)¹¹ considers that the lived oppression that people with disabilities have always experienced and continue to experience is a human rights tragedy of epic proportions. It is only recently that the world has started to register this reality, and also comparatively recently that the approximately 500 million disabled people worldwide have started mobilizing themselves into pressure groups to conscientise the world about their needs and plight. At the core of their call for recognition of those with disabilities are anger and contempt at the attempts of able-bodied people to theorise their conditions. Such theorisations are fundamentally flawed because of the medicalisation and depoliticisation of disability and a lack of accountability for the vast majority of the disabled who live in third world countries.

From a medical perspective disability has historically been considered a medical condition, and people with disabilities have been considered sick. Although people with disabilities are not diseased, they still form a medical category. If in the eyes of the medical and rehabilitation professionals who 'treat' them, they are seen first as a medical category then they are perceived as intrinsically ill with infirm bodies and/or minds. This sets people with disabilities apart and from the outset they are identified and perceived in terms of their bodies and appearance¹².

It is in the initial stage of becoming disabled that the person with a disability is most vulnerable and at this point that s/he is most likely to first be admitted to a hospital. Here the 'patient' is subject to the Foucauldian (1989:148) 'clinical gaze'¹³ which *"is not that of an intellectual eye that is able to perceive the unalterable purity of essences beneath phenomena. It is a gaze of concrete sensibility, a gaze that travels from body to body, and whose trajectory is situated in the space of sensible manifestation. For the clinic, all truth is sensible truth; theory falls silent or almost vanishes at the patient's bedside to be replaced by observation and experience."* This general hospital Foucault (2002:37) describes as *"not a medical establishment. It is rather a sort of semi-judicial structure, an administrative entity which, along with the already constituted powers, and outside of the courts, decides judges and executes"*¹⁴. It is in this situation that the first stage of

¹¹ Charlton, D. The argument. In: Charlton, D. (1998).

¹² Ibid

¹³ Foucault, M. Seeing and knowing. In: Foucault, M. (1989).

¹⁴ Foucault, M. The great confinement. In: Foucault, M. (2002).

disempowerment of the disabled takes place. And it is here that members of the medical team are corrupted by the power that this situation bestows upon them.
(Refer to Postcard #7 The Multiple Gaze page 222-223 Chapter 10).

Following a more appropriate epistemological route - The social model of disability

In contrast to the medical model which focuses on the problems caused by the impaired body or mind of the person with a disability, and which encourages a segregation of the disabled person from society in a society which itself remains unchanged, the social model advocates quite the opposite. The social model values the person with impairments, focusing rather on their strengths than their problems and taking society to task for not creating a culture in which barriers to integration are broken down, resources made available, and people with impairments integrated back into a community that evolves to accommodate the diversity that people with physical or mental impairment create.

The social model of disability was developed in Britain in the 1970s by activists within the Union of the Physically Impaired Against Segregation (UPIAS). It is today considered the ideological litmus test of disability politics in Britain, used by disabled people's movements to determine how progressive or otherwise organizations, policies, laws and ideas around disability issues are¹⁵. Oliver's definition in Shakespeare et al, (2002: 3-4) of the social model is as follows¹⁶:

"...in our view, it is society which disables physically impaired people. Disability is something imposed on top of our impairments by the way we are unnecessarily isolated and excluded from full participation in society. Disabled people are therefore an oppressed group in society. To understand this it is necessary to grasp the distinction between the physical impairment and the social situation, called disability, of people with such impairment. Thus we define the impairment as lacking all or part of a limb, organism or mechanism of the body¹⁷ and disability as the disadvantage or restriction of activity caused by contemporary social organization which takes little or no account of

¹⁵ Shakespeare, T. & Watson, N. (2002). The social model of d: an outdated ideology. Journal of Research in Social Science and Disability. Volume 2: 9-28. JAI Press.

¹⁶ Ibid

¹⁷ This aspect of the definition does not, in my opinion, adequately indicate the inclusion of mental impairment, thus lending itself to criticism of exclusivity for only those with physical impairment. This matter was later dealt with by critiques of the disability activist movements who included all people with any form of impairment

people who have physical impairments and thus excludes them from the mainstream of social activities."

Shakespeare & Watson (2002)¹⁸ cite key elements of this definition: firstly, it contends that disabled people are an oppressed group; further, it distinguishes between impairment and disability, where impairment denotes a biological condition, but disability is a state conferred or imposed through society's response (or lack of response) to impairment, constituting oppression of the impaired.

In its White Paper on *An Integrated National Disability Strategy (November 1997)*¹⁹ the office of the Deputy President of South Africa acknowledges the inadequacy of the medical model in meeting the needs of people with disabilities and supports the social model of disability as being a more appropriate, reconstructive and developmental ideology in meeting these needs. The social model thus forms the basis for the Integrated National Disability Strategy (INDS) in the current government of South Africa.

This model has been particularly important in the British disability movement in that it has provided the basis of a political strategy for the removal of disabling barriers from society for disabled people '**rather than pursuing a strategy of medical cure or rehabilitation**'. Thus it perceives social change and transformation, rather than the adaptation of the individual, as the ultimate solution. In addition to this, the social model has replaced the medical model view, in which the 'blame' fell at the door of the disabled, with one in which the 'blame' fell at the door of society. Thus disabled people no longer had to feel sorry for themselves - they could instead feel angry at society, creating a sense of empowerment²⁰.

Watson (1997)²¹ maintains that the medical and social models or constructions of disability are not as different from one another as they appear. Both these models, she contends, may have differing orientations but their intention is to promote optimum

¹⁸ Shakespeare, N. & Watson, T. (2002).

¹⁹ **Integrated National Disability Strategy**. (November 1997). The White Paper of the Office of the Deputy President. Rustica Press. Republic of South Africa.

²⁰ Shakespeare, N. and Watson, T. (2002).

²¹ Watson, R. (1997). **Should rehabilitation be redefined?** South African Journal of Occupational Therapy. Volume 27(1).

conditions for people with disabilities. The power and public positions that medical professions hold are granted by society because they heal and alleviate suffering and thus the traditional role of these professions of caring, curing and normalising humanity's ills are constantly reinforced. The expectations of medical professionals in defining what is '*normal*' or '*abnormal*' are transferred onto society. However, it is in this power, the control of what is perceived as being *normal*, as opposed to *abnormal*, and the deification of this 'normality', that the equation comes unstuck.

As occupational therapists are part of the rehabilitation team which has come under such negative scrutiny from disability activists, we too must be guilty of contributing to that oppression they speak of by our embracing so fully the medical model and not joining hands with the disability activists in advocating more for their rights. There are indeed some occupational therapists that have done so, but not enough of us. If present-day occupational therapists do not become serious and conscientised advocates for people with disabilities, they are not fulfilling the core purpose of their vocation, which is to facilitate the integration of people with impairments back into a fulfilling and meaningful life of which they are in control.

There are several aspects of the social model that I perceive as problematic, but these will be considered later in this chapter. It has, most importantly, resulted in people with disabilities all over the world uniting in different forms against the oppressive structures of society which disable them and that, in my opinion, makes it probably the most important model of disability in existence.

Disempowering and falling short of our ideals

I have previously alluded to one of the most disturbing facts emerging from the empowerment that the social model gave to people with disabilities, i.e. their lack of confidence in both the rehabilitation they received and those professions providing such services. And while the expression of these discontents caused rehabilitation professionals world wide to re-examine themselves and implement some changes in attitude and approach, there are, I believe, still issues related to so called 'therapeutic' approach and our interventions that need to be obliterated from our epistemology before we can even begin to restructure it. I will return to this in the concluding chapters of this thesis.

David Werner²², a well-known health rights activist, says that almost every field of human endeavor is approachable either in ways that are narrow and disempowering or ways that are expansive, enabling and liberating. However, despite their apparent ideology of 'service', the health professions still tend to be dominated by the narrow, disempowering approach. He proposes that the biomedical model with its elitist tendency and focus on the illness of individuals rather than their well being, and its inaccessibility to those who need it most, is to blame.

Werner puts it most aptly when he sketches the much larger and more holistic picture that occupational therapy fits into when dealing with how people function in their communities, and how it focuses on underlying social and community concerns. He maintains that "*in practice the occupational therapy profession too often falls short of its egalitarian goals.*" As a result, the poorest and neediest "*fall through the cracks. and in our globalised free market economy, there is no such thing as a free lunch. You get what you pay for*" (Werner, 2005:ix). This neo-conservative trend needs to be challenged, he argues²³.

Vic Finkelstein is a very vociferous disability activist and ex-South African who, after becoming disabled in a sporting accident as a young scholar, became very active in the underground anti-apartheid movement and was eventually jailed, wheelchair and all, together with notable people such as Bram Fischer. He finally left South Africa as a political refugee and is now settled in the United Kingdom. He draws a parallel between the segregation imposed upon black South Africans during apartheid with the universal segregation imposed upon disabled people²⁴. Finkelstein was one of the key persons, together with Colin Barnes and Mike Oliver, responsible for giving the social model of disability its academic credibility²⁵.

There are also those within the profession who are concerned at the inability of occupational therapy to realize its full potential and serve everyone in need of our

²² Werner, D. (2005). Foreword. In: Kronenberg, F. Algado, S. & Pollard, N. (Editors). (2005).

²³ Ibid: xi

²⁴ Finkelstein, V. (2002). **Whose history?** Keynote address at the Disability History Week, Birmingham, 10th June. <http://www.leeds.ac.uk/disability-studies/archiveuk/archframe.htm>

²⁵ Shakespeare and Watson (2002): 3

expertise, not just an elite few. Algado²⁶ has a humanistic vision which he reaches out to groups of people whom he feels occupational therapy had appeared to neglect or under-serve such as war survivors, prisoners, refugees, prostitutes, street children and people living with HIV/AIDS. In doing so he makes us aware of the need for our profession to engage with all people, and especially marginalised people who may be in need of our particular assistance.

Thus, while there is certainly a place for occupational therapists within the private market, I believe it would be the death of the soul of occupational therapy if we did not continue to concentrate most of our efforts in the public sector and non-governmental organizations whose major task it is to provide services for poverty stricken and marginalized people amongst others.

In their book "Occupational therapy without borders" Kronenberg, Algado and Pollard (2005:2)²⁷ are particularly concerned with the inherent *capacity* of survivors of traumatic physical, social and psychological experiences and the importance of occupational therapists being able to '*walk the talk of people-centered practice*'. They emphasise the importance of occupational therapists as citizens being able to work both within and outside of mainstream and medically oriented thinking and practice contexts, and deliberately not setting borders for the people they work with. This entails enabling those they serve to challenge the limits imposed upon them by the conditions by which they may be disabled.

Khulu's story is an example of how challenging limits is possible if one were to truly facilitate the dreams and aspirations that people with disabilities have. In a world such as the medical institution where people with disabilities commence their long journey, and where there is so much control exercised by all around them, the simple achievement of doing their own thing, however small, untainted by the orders and instructions of others, provides those with disabilities the first taste of that dream. It is facilitating this that should become the core motive in occupational therapy.

²⁶ Kronenberg, F. Algado, S. & Pollard, N. Preface. In: Kronenberg, F. Algado, S. & Pollard, N. (Editors) (2005).

²⁷ Ibid

Kronenberg *et al* (2005) do not suggest the replacement of expertise or clinical competence, but instead they advocate the sharing of expertise and competence specifically with those who are excluded from the privileges our expertise offers. They therefore ask what the 'borders' are that deny and restrict people from exercising their human right to meaningful participation in everyday life; what the 'borders' are that prevent or restrict occupational therapy from walking its walk or talking its talk and fleshing out its potential as a people-centered occupation. What is the nature of these 'borders', and who sets? Do we as occupational therapists set borders for others? In order to answer these questions, they maintain, we have to go beyond what they refer to as our limited grasp of 'holism'²⁸ and take on the full 'cross-border' connection of occupational therapy with its bases in art and science, not setting borders for those we serve, but challenging borders that restrict an individual's access to meaningful participation in daily life.

I suggest that, in the South African context, these borders have been mostly imposed by the power differentials previously discussed that undermine our epistemic authority and perpetuate the alienation and marginalisation of disempowered groups such as occupational therapists and people with disabilities.

Historical origins in the Western world of the relationship between disabled people and those who may work with them in a helping role: how does this parallel with South Africa?

Finkelstein²⁹ believes that the helper/helped relationship in Europe matured over a period of 300 years to what it is today. Prior to the industrial revolution in the United Kingdom and Europe, populations were predominantly rural, with production being mostly agricultural, some craft activity such as weaving of cloth, and a growing merchant trade. Food, clothing and other commodities were sold and purchased in the local market where trade increasingly dominated the economy, and one's social relations and survival were determined by one's ability to produce something that was saleable, being able to transport goods, or owning land.

²⁸ Ibid

²⁹ Finkelstein, V. Disability and the helper/helped relationship. An historical view. In: Brechen, A. Liddiard, P. and Swain, J. (Editors). (1981a).

In such pre-industrial societies social status was relatively fixed, everyone in small towns and village communities knew one other. People who survived severe physical impairment sustained either at birth or through injury or illness lived within their communities in close proximity to their able-bodied family and community members. Disabled people could more easily participate in the type of productivity that took place within homes at that time, such as child-care, cloth making or food production. In this way disabled people were far more integrated into community life.

With the advent of the steam engine the less efficient machinery that could be utilized at home for activities such as weaving and sewing, (which many disabled people could have done), was gradually replaced by more efficient machinery that produced cheaper and larger quantities of materials and garments. Market forces, mechanisation and the commodification of labour radically altered social structures, community life and human occupation and interaction. Capitalism and burgeoning industries sifted out the able-bodied from the disabled to carry out the work of production, and manufacture moved from rural to urban areas and from homes into plants and factories. Under these conditions it became virtually impossible for disabled people to participate in the same way and they became increasingly displaced and relegated to the fringes of society, where *“unemployed workers mingled with unemployable disabled people”* (Finkelstein, 1981a: 3). The increase in the numbers of unemployed people, thieves, vagabonds and disabled people on the streets created increasing concerns for the ‘authorities’³⁰. In this climate of demand for increased productivity those who did not or could not work were regarded with abhorrence and held responsible for their own circumstances³¹.

Disabled people were distinguished from those who would not work, or were unable to find employment, as being rightful recipients of charity and it was these circumstances that lead to the birth of ‘the institute’, In the UK disabled people ‘needed protection’ from their undesirable street-mates and were therefore placed in institutes or, if their families refused, kept out of sight of the authorities at home³². This ‘taming’ of people with disabilities was particularly relevant for those with psychiatric disabilities. From as early as the mid-17th century mental illness was linked with confinement. The state of

³⁰ Ibid

³¹ Ibid

³² Ibid

confinement was deemed the proper, natural condition for those with mental illness³³ leading to the establishment of enormous houses of confinement in cities such as Paris. This 'taming' and confining went on for a century and a half, and in many cases people with disabilities were confined in institutes that were specifically there for criminals, such as prisons and workhouses³⁴.

By the end of the 1800's and into the 20th century, institutionalization of disabled people was the norm and their only source of income was that derived from charitable contributions. This 'captive population' made it possible for the medical profession to study more explicitly, and at close quarters, some of the conditions of those held captive. The first and second world wars substantially increased the numbers of disabled people in Europe and by the second world war, this gave impetus to the development of specialisms within those professions that worked with disabled people, such as occupational therapy³⁵.

By this stage disabled people had become firmly isolated and dependent upon specialized health professions and non-religious charitable organizations for their care and support. These organizations, run by able-bodied people became the 'mouthpieces' of the disabled people they represented, thereby further suppressing and marginalizing the voices of those with disabilities. After this fashion a society that was 'uncontaminated' by the presence of disabled people for centuries designed a world that did not recognize the existence of disabled people and reinforced the common perception of disabled people as being passive recipients of institutionalization and charity³⁶.

The relationship between the helper and helped at this stage is critical and the power vested in the helper is enormous. It is therefore of significance to this thesis to acknowledge the fact that occupational therapists fall within the classification of those who are helpers. Finkelstein maintains that professional practice that grew up on the basis of social exclusion of disabled people led to practices by these professional helpers that erected further barriers to the development of those they were supposed to

³³ Ibid

³⁴ Foucault, M. The great confinement. In: Foucault, M. (2002).

³⁵ Finkelstein (1981a).

³⁶ Ibid

serve. It was this 'active controlling' by the helpers of those they helped that was the major impediment to the integration of disabled people back into the community.

Charlton maintains that the primary method through which power is exercised over disabled people is not physical, but rather metaphysical i.e. through people's consent to the existing power³⁷. This is particularly true in the initial stage of disability, that vulnerable stage when the person's life may be at stake and thus placed under the control of the doctor. Later, with their perceived future independence and quality of life at stake, they succumb to the rehabilitation professionals who are treating them.

What is happening today is that the discourses of disabled people have become outspoken and vociferous against the forces that oppressed and marginalized those with disabilities in the past. The helper/helped relationship is gradually evolving into one of equality. Finkelstein maintains that this relationship should be a collaborative one in which the person with a disability is included in all decision-making processes that involve them, and this thinking is permeating current practice³⁸.

Two key questions arise from this brief historical overview of the status of disabled in Europe. Firstly, in spite of current discourses in occupational therapy condoning collaborative and equitable decision-making processes between helper and helped, to what extent have the old, active controlling and attitudinal barriers of the past have been carried into the future?

The second question is how do the origins of the helper/helped relationship in South Africa differ from those in Europe? This question necessitates dividing the investigation into separate origins for white South Africans and those races other than white, particularly ethnic African. The origins of this relationship for white disabled people living in South Africa are very similar to for those in Europe. However, amongst the so-called non-white³⁹ race groups the relationship was complicated the racist and oppressive legislation and attitudes of whites in the days of apartheid. It is not difficult to imagine

³⁷ Charlton, D. The dimensions of disability oppression. In: Charlton, D (1998).

³⁸ Finkelstein (1981a)

³⁹ Non-white was the term used in the apartheid era to designate all races other than European. Thus African, Asiatic races or any mixture of these with European races were designated non-whites.

that if white disabled people of those days were oppressed and marginalized, then those of the Asian, African and Coloured race groups were exposed to a far more extreme and destructive marginalization and oppression, especially if they were cared for by a caregiver or professional who was white.

It is hardly likely that occupational therapists practicing in the apartheid era deliberately marginalized and oppressed those patients of other race groups that they treated. I am sure that their intentions were honorable and based upon a genuine need and desire to help their patients. However, I suggest that the potent combination of their position of power over the patient by virtue of apartheid ideology, their inadequate knowledge of the language, cultural needs and nuances related to disability within race groups other than white, the strong bias in the profession towards the medical model, and a regulatory system that made access to the services (which, when accessed, were inferior to those for whites) of occupational therapists difficult was in itself a recipe for oppression and marginalisation.

Cultural differences, indigenous knowledge and disability

At this point it is necessary to separate the type of helper/helped relationships that existed as a result of the apartheid regime from those that existed within the specific cultural contexts of African, Asian and Coloured people during the time of apartheid.

In traditional African culture illness and disability can be associated with two main causes. The first relates to the protection offered by the ancestors who have to be appeased if one has committed an act that is believed to have angered them. With particular reference to the Zulu culture, there is a distinction between ancestors who can punish or reward and those who are powerless to do this. The ancestors closest to the patriarch of the home are seen as the most powerful. If one does not appease the ancestors adequately through sacrifice of an animal and other rituals, then the protection they offer is withdrawn⁴⁰.

Thus, if someone in the family becomes disabled either at birth or through trauma or illness, it can be perceived as a punishment from the ancestors for some or other failure

⁴⁰ Ngubane, H. The ancestors and illness. In: Ngubane, H. (1977).

in on the part of the family to obtain ancestral approval. The presence of a disability in the family is thus an embarrassment, because it is interpreted as a sign to the community that the ancestors of that family are angry. It is therefore not uncommon for disabled people, especially children, to be kept isolated and out of sight of neighbours and other community members⁴¹. The ostracism experienced by people with disabilities thus results in a type of isolation and marginalisation similar to that described by Finkelstein above.

The nature of the stigma that can be attached to disability is apparent in the very language used to refer to those with disabilities: Ranga Mupinda (Charlton, 1998: 46)⁴² says that “*in Africa in our culture, we do not even use the awful word ‘cripple’. It’s even worse in Shona, the word is chirema, which means totally useless, a failure. So a person with a disability begins life as a chirema*”. The Indebele word for disabled people is *isigoga*, which connotes helplessness, and many of the words used for blind and deaf people connote helplessness⁴³. In isiZulu an albino is often referred to as *iNkawu*, the isiZulu word for a monkey.

A second perceived cause (using Zulu culture as example) for one becoming disabled is based upon the belief that witchcraft or sorcery (*ubuthakathi*) can be used to make a person ill or disabled as in the case of Khulu in narrative story 7. It is held that, because humans, when in motion, absorb certain elements of their immediate surroundings, sorcerers (*abathakathi*) are able to deliberately cause harm to a particular person by placing harmful substances/medicines (*umuthi*) in places or situations where they will come into contact with the target. Usually this is done at the request of a third person who wishes to harm someone against whom they may have a grudge. In this case a spell may be cast through a sorcerer (*umThakathi*).

There are distinctions between day and night sorcery: day sorcery usually occurs as a result of personal animosity such as competition, rivalry or jealousy and usually takes

⁴¹ This information is based upon anecdotal evidence conveyed to me by Zulu colleagues and health workers who have worked with me for the past 12 years in community based education projects in the Kwadedangendle area commonly referred to as the Valley of 1000 Hills.

⁴² Charlton, D. Culture(s) and belief systems. In: Charlton, D. (1998).

⁴³ Ibid

the form of adding noxious medicines or western poisons to the victim's food⁴⁴. While persons becoming disabled as a result of sorcery are not necessarily marginalized by their community, they live with the anger, resentment and fear that someone has deliberately caused them to become disabled. The fear of further sorcery may cause them to isolate themselves from society.

African people with disabilities do not necessarily condone or subscribe to these beliefs, for example Joshua Malinga⁴⁵ in Charlton (1998:63)⁴⁶ says *"...in Africa we have very backward ideas about disability connected with witchcraft and to life as an oppressed people historically"*. He is supported in this by Ranga Mapundi⁴⁷ who says, *"People who were superstitious believed evil spirits had cursed me"* (Charlton 1998:63).

In addition to indigenous South Africans with their own unique cultures, there are also other cultural and religious groups, other than White Christians, for example Hindu, Muslim and Chinese, each having their own cultural and religious ideologies that shape attitudes and may determine discrete ways of dealing with the disabled and issues of disability.

Miles⁴⁸ suggests that the knowledge, attitudes and practices of most Africans towards disability and people with disabilities has some historically accumulated components based upon their past institutional and cultural heritage. But the historical knowledge about disability in Africa has largely been the concern of the 'voiceless' minority, who were and are cared for largely by women, and nobody has collated or collected this knowledge. Most historical studies, he maintains, have focused on earlier African cultures, colonial exploitation and national liberation struggles rather than the efforts of weaker, minority groups to better the situation of people with disabilities.

⁴⁴ Ngubane, H. The ancestors and illness. In: Ngubane, H. (1977).

⁴⁵ Joshua Malinga was then the chairperson of Disabled Peoples' International and General Secretary for South African Federation of the Disabled (SAFOD) and Mayor of Bulawayo.

⁴⁶ Charlton, D. Culture(s) and belief systems. In: Charlton, D. (1998).

⁴⁷ Rangarirai Mapundi was then Executive Director of the National Council of Disabled People Zimbabwe. (Charlton, D. Culture(s) and belief systems. In: Charlton, D. (1998).)

⁴⁸ Miles, M. (2001). **History of educational and social responses to disability in Anglophone Eastern and Southern Africa: Introduction and bibliography. The history of education and childhood.** <http://www.sosci.kun.nl/ped/whp/histeduc/mmiles/aesabib.html>.

Credo Mutwa⁴⁹ provides some idea about how African legends contribute to the negative attitudes that emerged in Africa towards people with disabilities. He tells of an African legend in which the Great Mother and Goddess of creation was herself imperfect (disabled?) and passed on these imperfections to her children. The birth of the first deformed child resulted in her flight from a threat by her people to destroy the child. Surviving these threats, the child develops into a monstrous and destructive tyrant. Mutwa suggests that the infanticide of disabled children that occurs in some African tribes is a pre-emptive measure to prevent this fabled tyrant from being reborn.

A brief review of the status of people with disabilities during the apartheid era

This information has been taken from some of my own personal recollections as well as perusal of some of the volumes of the Co-Ordination Committee for the Year of Disabled Persons 1986 titled Disability in the Republic of South Africa. These volumes were compiled by a co-ordinating committee elected by the Department of National Health and Population Development in Pretoria in November 1987 as an attempt by the apartheid government to show its alliance with people with disabilities during the year of Disabled People in 1986.

The series consists of a main report and 36 supporting reports/volumes. To peruse and analyse all these volumes (some of which are 260 pages long) would be an impossible task and is not essential to this thesis, so I have extracted selected sections from some of the reports to illustrate the oppressive, disempowering attitudes and regulatory context of those days. These and the discussion that follows will demonstrate how this oppressiveness and disenfranchising government's hold extended, not only towards people of races other than white, but also towards people with disabilities.

Firstly: the co-ordinating committee for the compilation of these volumes was established '*in accordance with the resolutions of the Cabinet on 20 November and 3rd December 1985*' (1) and the Department of National Health and Population Development (2) was instructed to act as Co-ordinator of the Year of Disabled People,

⁴⁹ Mutwa, Credo Vusamazulu. (1998). **Indaba my children. African legends, customs and religious beliefs.** Paperback Press. Edinburgh.

1986. The co-ordinating committee that was established for this purpose consisted of representatives from 19 government departments and 13 persons from the private sector (3). Under this committee 14 sub-committees, 14 working committees and 4 main working committees (Prevention, Treatment, Development and Care) were appointed to undertake '*a generic investigation with regard to the spectrum of the care of disabled people on the basis of guide-lines that were made available to them in a report format.*' It is also important to note that this investigation excluded the '*independent National States*⁵⁰ of Transkei, Ciskei, Bophutatswana and Venda (this would also automatically exclude the Self Governing states (see footnote 53). (4) The ultimate purpose of this investigation by the co-ordinating committee and working groups was to *formulate a general policy and create strategies* (5) but the report does not expand upon what strategies it will create in its chapter 1 of volume 2 of this report⁵¹.

Comment 1:

This enquiry into the *spectrum of care of disabled people* was initiated at cabinet level of government (1) as an attempt by the Nationalist Government, (which was considered a pariah by most of the rest of the world because of its apartheid policies), to raise its credibility internationally by promoting its participation at the highest level in the International Year of the Disabled in 1986. This move typically commenced the process of situating the entire investigation under government control, nested finally within the Department of National Health and Population Development (2). State control was further strengthened by numerically weighting the government's representation on the committee by 19 as opposed to 14 non-governmental members (3). Ironically though, the investigation excluded the Independent and Self Governing States, which held millions of South Africans, and of these it can be roughly estimated that at least 12.3%⁵² would have been disabled at the time. (4). The ultimate aim of

⁵⁰ The Natives Land Act of 1913 and the Natives Trust and Land Act of 1936 divided South Africa into 'white' (including Coloured and Indian) and African areas. The Pass Laws and Black Urban Areas Act of 1945 (as amended) gave the Government power to decide which Africans could stay in 'white' areas and which couldn't. In the 1960's the engineering of forced removal of Africans commenced under the Nationalist Government and by the late 1970's an estimated 3,5 million people were removed from white areas, many back into the so called Independent States or homelands. By 1984 there were 4 Independent States and 6 Self Governing States in which millions of Africans lived. In: Saunders, C. (1998). (Editor) **The Readers Digest illustrated history of South Africa – The real story**. Readers Digest Association Ltd. Cape Town.

⁵¹ Disability in the Republic of South Africa. (1987). **Volume 2: Prevention**. The Co-ordinating Committee: Year of Disabled November. Department of National Health and Population Development. Pretoria.

⁵² Charlton, D. Culture(s) and belief systems. In: Charlton, D. (1998).

creating policies for people with disabilities and strategies for their care (5) should, if democratically constituted, dictate that such an investigating committee or working group would of necessity have people with disabilities (PWDs) and organisations for PWDs strongly representative on these committees and working groups. As will be seen in the tables 5 and 6 below, these committees and working groups appear to have been dominated by government officials, professors and doctors, mostly white males, with only a smattering of other races, women and people with disabilities represented on them. It is typical of the type of unilateral control exercised at the time that a co-ordinating committee and working group so comprised was put in a position to make decisions and complete research around disability issues.

Key to abbreviations on Tables 7 and 8:

Prof	Dr	Adv	Brig	Mr	Ms	A	C	In	W	M	F
Professor	Doctor	Advocate	Brigadier	Mister	Miss or Mrs	African	Coloured	Indian	White	Male	Female

Table 7: Demographic Breakdown of Work Group on Disability: Prevention: Year of Disabled 1986 Σ 16

Institution Represented	Status						Race group				Gender		Disabled
	Prof	Dr	Adv	Brig	Mr	Ms	A	C	In	W	M	F	
Government	0	3	0	1	1	2	0	0	0	7	5	2	0
Non-Government	0	1	0	0	1	0	0	0	0	2	2	0	0
Academic	4	1	0	0	0	0	0	0	0	5	5	0	0
Disabled	0	0	1	0	1	0	1	0	0	1	2	0	1
TOTALS	4	5	1	1	3	2	1	0	0	15	14	2	1

Table 8: Demographic Breakdown of Work Group on Disability: Treatment⁵³: Year of Disabled 1986 Σ 19

Institution represented	Status						Race group				Gender		Disabled
	Prof	Dr	Adv	Brig	Mr	Ms	A	C	In	W	M	F	
Government	3	6	0	0	2	1	0	3	1	7	11	1	0
Non-Government	0	1	0	0	0	0	0	0	0	1	1	0	0
Academic	2	2	0	0	0	0	1	0	0	3	4	0	0
Disabled	0	0	0	0	1	1	0	0	0	2	1	1	2
TOTALS	5	7	0	0	3	2	1	3	1	13	17	2	2

The analysis of the demographics of these two working committees clearly reveals the extraordinary bias in favour of white males (88% and 89% respectively), many of whom were professors or doctors of one or other medical specialty (56% and 74% respectively). It seems extraordinary that the working group for Treatment of Disabled consisted of nearly 74% medical specialists, only one nurse and one physiotherapist (11%), and not a single occupational therapist or speech therapist/audiologist. One would expect a working group that was dealing with the “treatment” of people with disabilities to be far more heavily represented by rehabilitation professions than medical doctors. This further illustrates the marginalization of occupational therapists by the government of those days and the hegemony of the medical professions in all matters related to health care including areas that they were not adequately trained to deal with such as rehabilitation and the promotion of quality of life.

In addition to this, these two working groups consisted of predominately whites (94% and 68% respectively) as opposed to other race groups (6% and 26% respectively) and non-disabled people (94% and 89% respectively) as opposed to people with disabilities (6% and 11% respectively).

In summary, this meant that predominantly medically oriented, male, white and non-disabled working groups were responsible for researching and designing strategies and policies for a predominantly “non-white”, gender-mixed group of people with disabilities.

⁵³ Disability in the Republic of South Africa. (1987). **Volume 3: Treatment.** The Co-ordinating Committee: Year of Disabled November. Department of National Health and Population Development. Pretoria.

Given the constitution of these two working groups it is highly probable that the other two working groups would have been similarly constituted. It is impossible to believe that such a biased committee could produce fair and equitable policies and strategies for the prevention, treatment, development and care of all people with disabilities in South Africa. Evidence for this claim will be offered in the analysis of some extracts from the volumes compiled by the two working groups already considered.

Like the constitution of the working groups, the contents of these voluminous documents also reflect the power wielded by the Government at the time, and perpetuate a one-sided dictatorial and non-democratic stance. For example, an extract under Chapter 2⁵⁴ *“The Ethical Point of Departure and Basis”* illustrates the partisanship and intolerance on the part of those in control at the time towards any religious or cultural differences that went contrary to their own ideology:

*“The reality of religious plurality (1) in South Africa makes a narrow ecclesiastical approach impossible. Meanwhile, however, it is also true that approximately 77% of the total population (2) (1980 census) belong to the Christian faith, with the result that in certain cases it will be possible to refer specifically to Christian views (3) The recently completed HSRC⁵⁵ investigation into intergroup relations showed, **inter alia**, that there is a high level of agreement among the various churches about the basic values and norms with regard to a subject such as human rights ... the Judeo Christian origins of certain values and norms have over the centuries had an effect upon legal systems, systems of government, democratic practices, customs, (4) etc., with the result that these values and norms are accepted today even by non-Christians (5) as part of particular Western or even universal way of life (6).*

Comment 2:

The reality of religious plurality (1) was that the country consisted of large numbers of people of other faiths such as Hinduism, Islam and Buddhism, as well as large numbers of African people whose religion incorporated ancestor worship. The possibility, then, of getting all South Africans

⁵⁴ Disability in the Republic of South Africa. (1987). **Volume 2: Prevention.** The Co-ordinating Committee: Year of Disabled November. Department of National Health and Population Development. Pretoria.

⁵⁵ Human Sciences Research Council was then a Nationalist Government controlled Research Council that promoted and sponsored research that complied with its specific criteria.

to take ownership of any strategy for disabled persons that was so partisan would have been, and still is, highly unlikely. Let us also not forget that when the voice of authority speaks of a group of approximately 77% of the total population (2) this also excluded the millions displaced into Independent and Self Governing States. It is totally hypocritical and paradoxical that this committee dominated by a government whose ideology was exclusivist and exclusionary, was racist and extremely oppressive, could equate itself with Christian views, customs, practices, values and morals etc (3 and 4) which run totally opposite to all that apartheid stood for. The arrogance and insensitivity of suggesting that these values and norms are accepted by non-Christians (5), and the imposition of Western values (6) upon such a culturally diverse country is reflective of the lack of sensitivity to participation of, and collaboration with other religious and cultural groups (within these working groups). A more eclectic and democratic approach would have ensured greater participation and ownership by all South Africans and promoted the development of a strategy and policy on disability that would have been widely acceptable to South Africans.

I will conclude the discussion on the analysis of these documents by briefly including two extracts from Volume 3 of Disability in the RSA (1987) on Treatment. The following extract illustrates the manner in which the reality of the injustices towards so many disabled persons at that time in South Africa is couched in euphemisms:

'As already mentioned, the Republic of South Africa (RSA) is unique (1) in that the various population groups (2) are in different stages of development (3) and in that the size of the country leads to great geographic and geological differences (4) that are characterized by considerable distances and differences in agriculture, climate and population density (5). These differences influence the ecological balance between people and their environment and therefore also the agents that cause illness (6). This results in various types of illness influences the nutritional status of the inhabitants (7) and inevitably has a significant influence on the nature and extent of the provision of health services in these regions (8).

Comment 3: The uniqueness of the RSA (1) was that no other country in the world had such an oppressive and racist government, which legalized and enforced the segregation of population groups (2). The implication of the comment that these population groups are in different stages of development (3) is that there is a hierarchy of development in which the whites are at the top and other races at various less developed stages below them. Thus disabled persons of other race

groups, especially Africans, would have been considered to be on lower levels of development than those of white disabled, immediately placing them at an additional disadvantage. The density of population, geographic, climatic and agricultural differences described in (4) and (5) are as a direct result of the fact that blacks were displaced into their so called Independent and Self Governing States which were generally over-populated, usually established in the least fertile, drought-stricken and geographically and geologically hostile regions of South Africa. The resultant illnesses and nutritional status of the inhabitants (7) was largely due to widespread poverty amongst African people, many of whom were unemployed, and also the fact that agriculture in some parts of these States was poor, thus food production was limited, especially in times of drought. Ironically the “agents” that cause illness (6) are in this case euphemisms for the poverty and gross disadvantage inflicted on the majority of the population through the implementation of apartheid ideology. The provision of health care varied from region to region i.e. in the Independent States it was very poorly resourced and inaccessible and in the RSA it was well resourced and easily accessible for urban persons and not so for rural persons. (8)

It is interesting that this investigation states at the outset that the Independent States are to be excluded from its ambit, yet alludes to their inclusion by the very essence of what is described in the above extract (2,3,4,5,6,7,8). Because of the poor health resources in the Independent States, most inhabitants of these States had to access tertiary care in the RSA, thus making it impossible to exclude them from such an investigation.

The above extracts briefly illustrate how the entire political milieu of that time in history mitigated against the just and equitable formulation of policy and a strategy for the prevention, treatment and care of people with disabilities. It thus also raises the question as to how the development of an occupational therapy epistemology against this background and under these circumstances could have been anything other than flawed.

Returning to the social model of disability and its link with feminism

It is the social system, which disables people with impairments, forcing them to live in a social prison. Thus the only way to emancipate disabled people is to dismantle the

prison and replace it with a non-competitive society⁵⁶. This is the basic tenet of the social model of disability. The current obsession that Western societies have with perfect bodies is played out in a plethora of billboards, television ads, films and reams of glossy magazines filled with images of people with perfect features and perfectly modeled bodies coupled to an inexhaustible industry of gyms and products that can contribute either to the creation or maintenance of this perfect body. Such obsession with perfection of body contributes to the marginalization of people with disabilities and adds to the stress they must experience when trying to compete with such obsession in a world already full of stressors.

Finkelstein⁵⁷ sees human beings as essentially weak, vulnerable and physically imperfect by nature, but maintains that throughout history people without disabilities have tried to intervene in the body structure of people with disabilities, marginalizing them all the more. Those without disabilities thus transfer their own vulnerability onto disabled people, creating an impression that the vulnerability of people with disabilities is a condition unique to people with disabilities which separates them from people without disabilities.

Watson⁵⁸ maintains that the discrimination against disabled people occurs in almost all aspects of their lives, spanning both public and private spheres, which poses a challenge to those who maintain that disability is an individual experience occurring as a result of personal misfortune. As feminism distinguishes between sex and gender, disability studies and the social model distinguish between impairment (i.e. the physical component) and disability (i.e. the socio-cultural component). The conceptualization of disability as a form of social oppression turns disabled people into a distinct social group in a similar manner to the way that black people, gays and lesbians have claimed such social oppression through their respective political movements. To be an activist whether as black, gay, woman or disabled person converts the label into a badge and creates a healthy oppositional culture⁵⁹.

⁵⁶ Finkelstein, V. (2001). **The Social Model of Disability Repossessed**. The Manchester Coalition of Disabled People – 1st December: 1-5. <http://www.leeds.ac.uk/disability-studies/archiveuk/archframe.htm>

⁵⁷ Ibid

⁵⁸ Watson, N. The dialectics of disability: a social model for the 21st Century? In: Barnes, C. & Mercer, G. (Editors). (2004).

⁵⁹ ibid

More than anything else, the social model of disability has been a useful political tool and strategy to mobilize people with disabilities into becoming advocates against the systems and societies that have disabled, marginalized and oppressed them. It provides the means for changing the perceptions of people without disabilities about people with disabilities and transforming the mass of disabled people into a politicized group in which their personal discontent can be translated into a public struggle⁶⁰. The social model has thus challenged the medicalised compartmentalizing of disabled people into professionally controlled groups of impairment and offered them commonality and community in the shared experience of resisting oppression.

The social model also lays the ontological and epistemological basis for producing emancipatory research, particularly by focusing on socially constructed barriers. This type of research attempts to demystify the structures and processes that create disability. As such, it is partisan in that it is accountable to disabled people, their organizations and struggles; it focuses on empowerment, it reverses the traditional researcher/ researched hierarchy as well as the social relations of research production and it challenges the material relations of research production, accepting instead a plurality of research methodology⁶¹.

For these reasons, and because the new, democratically elected government of South Africa has used it as a basis in structuring its Integrated National Disability Strategy, the social model is, in my opinion, the model of disability that is currently most appropriate in articulating the position of disabled people in South Africa and transforming that position to one of greater control and confidence, which is critical at this stage in the history of disability activism.

Imperfections in the Social Model: a Critique

There are, however, shortcomings in this model that I must briefly address.

⁶⁰ Ibid

⁶¹ Mercer, G. From critique to practice: Emancipatory disability research. In: Barnes, C. & Mercer, G. (Editors). (2004).

Firstly, in its mostly justified disassociation from, and hostility towards, health professionals and particularly rehabilitation professionals in the early days of its development, the opportunity was lost for collaboration in an exploration of ways in which a more acceptable and serving health professional could be developed. In its close association with emancipatory paradigms the social model tends to fall into stereotyping and caricaturing the relationship of rehabilitation professionals to the positivist medical model without appreciating and acknowledging ways in which these professions are attempting to change themselves.

This hostility within the model creates a vacuum between the two sets of people who should rather be collaborating towards the re-creation of a process in which there is the development within such professional cadres of sensitive advocates and agents concerned with the critical care and empowerment of people with disabilities during their recovery.

I have no doubt that the rehabilitation professionals are mostly to blame for this in view of their failure to bring in people with disabilities from the start to negotiate ways in which they could collaborate. This was clearly evidenced in South Africa's history of formulating strategies and policies for people with disabilities during the founding years of occupational therapy as discussed previously in this chapter. However, the disability movements would have gained ground and changed this trajectory had they taken the initiative and formed pressure groups to oppose the lack of their inclusion in issues related to them.

A second concern revolves around the social model's obsession with the disabling nature of society and those health professions who should contribute to the rehabilitation of disabled people. Because of this, the social model underrates and underestimates the very real issues of tragedy and loss that are concomitant with any condition that results in major and permanent physical or psychological impairment. Even if the world changed tomorrow and every existing human, environmental, attitudinal and other social barrier were removed, people with serious physical and/or psychological impairments would still commence their journey of recovery feeling a sense of loss, of tragedy and a need for return to where and who they were before. To expect them to overcome these

transitional obstacles without adequate support, encouragement and assistance is both insensitive and unrealistic.

A third area of concern is related to the social model's origins within the Union of Physically Impaired Against Segregation (UPIAS)⁶². Because of its foundations within a union of **physically** disabled people, it fails to adequately address the very relevant and important issues related to individuals with mental impairments. With few exceptions, writings from disabled activists contributing to this model revolve around issues related to individuals with physical disability. This thus creates a sense of *we-they* and othering between physically and mentally disabled people. In so doing the model becomes trapped in the very meritocracy of which it accuses organizations for disabled people run by able-bodied people.

Furthermore, the model is also located in British disability politics⁶³ and thus, although it speaks universally for all people with disabilities throughout the world, it fails to address the political and cultural idiosyncrasies and nuances of disabled people from other countries and especially, in this context, from Africa.

However in spite of these criticisms, I sincerely commend UPIAS, the founders of the model. They have done an excellent job in raising disabled people out of the marginalized and oppressive swamp in which they had been mired during the late 1960's and 1970's⁶⁴. It has been largely responsible for decolonizing disability organizations, which had previously been colonized by experts without disabilities, and has put people with disabilities at their helm⁶⁵. It has resulted in raising public awareness

⁶² **UPAIS**: the Union of Physically Impaired Against Segregation originated in the United Kingdom in September 1972, from a letter published in the Guardian by Paul Hunt calling for people with disabilities to form their own organisation. It originally functioned mostly through confidential correspondence exchanges and circulars amongst its members. These lead to the formulation of a policy statement in 1974 and in 1976 the formulation of the Fundamental Principles of Disability, which became the foundation for the Social Model of Disability. (Barnes and Mercer: 2004)

⁶³ Shakespeare, T. & Watson, N. Defending the social model. In: Barton, L. & Oliver, M. (Editors). (1997).

⁶⁴ Barnes, C. & Mercer, G. Theorising and researching disability from a social perspective. In: Barnes, C. & Mercer, G. (Editors). (2004b).

⁶⁵ Ibid

throughout the world, about the potential of disabled people to mobilize and stand up for themselves. More importantly, it has also given health professionals who work with disabled people an entirely new perspective that, for those of us sensitive to its message, has raised profound questions about the epistemologies surrounding our own professions and the need to revisit these.

I believe the entire civil rights context within which this model was born, and the process through which it developed, provides the foundation upon which it can be further developed to be a more inclusive and comprehensive model representative of people with every kind of impairment throughout the world. In order to do this, its supporters need to engage with all role players and stakeholders globally, which appears to be happening more willingly in this new millennium.

Having explored the controversial issues related to disability, its marginalization by society generally and the negative perceptions that people with disabilities tend to have of health professionals, this chapter has also tried to provide evidence from historical data analyzed, to reinforce these perceptions and show how it has impacted upon the development of the occupational therapy epistemology. The following chapter will now explore the issue of racism and diversity which was rife in the days of the development of occupational therapy in South Africa and how this has impacted upon our epistemology.

CHAPTER SEVEN

Diversity, Racism and Indigenous Knowledge: Roots left out of the epistemological tree

Route map: This Chapter will briefly revisit the origins of racism in Africa, and the impact of colonialism and apartheid on the health and wellness of its people. It will reveal how this history has perpetuated a negation of indigenous knowledge systems in South Africa and how this has impacted upon both the development of the profession of occupational therapy and its epistemology and guide the researcher's point of view and provide the lens through which data will be analysed.

Vignette #3: Sitting opposite a black face

"I sit quietly for a long time. Not so much embarrassed as deeply aware of the extent to which my perception of being in this world is constantly informed by this African-ness. Black-ness or African-ness I don't really know, but it is a way of looking at the world that neither I, nor the culture I grew up in, nor the books I have read are able to come up with. I seem to find it only when I sit opposite a black face." (Antjie Krog, 2003)¹

Significant historical perspectives and origins

Since the time of Plato, and particularly that during the period after the 17th Century informed by the specific influences of Cartesian rationalism and Lockean empiricism, Western philosophies have (pre)-occupied themselves with the relationship between the knowing subject and its object. These subject/object relations also infiltrated the younger discipline of anthropology, and within the growth and development of this relatively new science of culture, race became the determining factor. This thinking also influenced how Caucasian races came to *think* and construct the cultural paradigms of *other* non-Caucasian races in such a way as to consolidate the African image in the power-knowledge system of colonialism and the post-colonial period²

¹ Krog, Antjie. (2003). **A change of tongue**. Random House Publishing. Rosebank.

² Biakolo, E. Categories of cross-cultural cognition and the African condition. In: Coetzee, P. & Roux, A. (Editors). (1998).

So it was that, in the early 1900s, in the framework of this ideology, the Euro-American society granted itself the status of being civilised whilst other races, and particularly the African races, were described variously as 'barbaric' 'uncivilised' and 'savage'. In the 1980's other anthropologists further added to this insulting ideological discrimination by, for example, maintaining that primitive cultures like those in Africa had a pre-logical mentality unable to reason beyond the synthetic. Members of these cultures were considered to be poor at analysis and concrete in their thinking with little capacity for abstraction, and hence inadequate when pitted against Western logic. Another discriminatory association was that of connecting primitive knowledge-schema with magic or perceptual thinking and Western knowledge-schema with science or conceptual thinking. The former is considered conservative, recreating existing structures in a manipulative way whilst the latter is considered innovative and ever inventive of new technological forms ³.

Other schools of anthropological thought believed that Western civilisation owed its civilised origins to writing. In other words, without literacy many of the Western innovations of today would not exist. In contrast African oral cultures were perceived as conservative and traditionalist with knowledge and skill acquisition being based upon personal participation and practice and conceptual knowledge categories being concrete and interiorised as communal knowledge ⁴.

This Afro-pessimism has been perpetuated since the advent of Western colonisation and still continues today in the minds of many Westerners. Steve Biko (1998:26)⁵ expresses the anger and indignity this caused African people in the following quote..."*since that unfortunate date – 1652 - we have been experiencing a process of acculturation. It is perhaps presumptuous to call it 'acculturation' because this term implies a fusion of different cultures. In our case this fusion has been extremely one-sided. The two major cultures that met and fused were the African culture and the Anglo-Boer culture. Whereas the African culture was unsophisticated and simple, the Anglo-Boer culture had all the trappings of a colonialist culture and therefore was heavily equipped for conquest. Where they could they conquered by persuasion, using a highly exclusive religion that*

³ Ibid

⁴ Ibid

⁵ Biko, S. Readings: Some African cultural concepts. In: Coetzee, P. & Roux A. (Editors). (1998) *Philosophy from Africa: A text with readings*. Thomson Publishers, South Africa.

denounced all other gods and demanded a strict code of behaviour with respect to clothing, education, ritual, and custom. Where it was impossible to convert, firearms were readily available and used to advantage. Hence the Anglo-Boer culture was the more powerful culture in almost all facets. This is where the African began to lose grip on himself and his surroundings”.

However Biko⁶ is against the notion that with this conquest of the African all their culture was obliterated. He believed that, in spite of the severe blows that the African culture has had to sustain in its collision with the ‘*belligerent cultures*’, even today it is possible to find the fundamental aspects of the pure African culture in the contemporary African. Thus, although the modern African may today easily blend into Western cultures and may also subscribe to certain Western values and practices, the inner core values of being African remain. Biko describes the new and modern culture that is emerging as “*a culture of defiance, self assertion and group pride and solidarity*” (Biko1998: 26). A culture which, he maintains, has emanated out of the group experience of oppression.

Based upon these comments of Biko’s and with reference to the essence of this thesis it is necessary to pose the rhetorical question of whether occupational therapists practising in South Africa today truly understand these inner core values and the emerging characteristics of the contemporary African. And following from this, is it not an essential for all occupational therapists to understand such issues if they are to work together with African people with disabilities in facilitating their attainment of independence and quality of life regardless of one’s race?

In addition to the years of informal discrimination common in most of the colonised countries of Africa, with the coming to power of the National Party Government in South Africa in 1948, a new and more terrible institutionalised system of racial oppression, *apartheid*, came into being⁷: a system that permeated everything and everyone who lived under it. And which, I suggest, resulted in whites falling into one of three broad categories: either they agreed with it and thus supported the structures that fed it; or they

⁶ Ibid

⁷ Watson, R. & Fourie, M. International and African influences on occupational therapy. In Watson, R. & Swartz, L. (Editors). (2004).

*ostrichised*⁸ themselves and carried on life as if nothing was amiss, inwardly aware of the wrongness of *apartheid* but too complacent or afraid to do anything remarkable about it; or, and only a few did this, they fought the system together with the victims, putting themselves at great risk in the process. I personally believe that most whites in South Africa fell into the second category.

Given the rapid progress that South Africa is making under a democratically elected Government, which is primarily made up of black South Africans, it is a tribute to the incredible resilience of the African people that, in spite of the hugely destructive forces that worked upon their culture and philosophy, in the celebration of their freedom, they have been able to rise above these forces and commence the reconstruction of their very essence as a people of Africa. I believe, however, that one should not underestimate the traumatic effects of this history upon the African psyche, and that those of us who wish to support their endeavour in picking up and putting together the pieces of their battered humanity should do everything possible to respect, and not to interfere with their need for reconstruction and acknowledgement of their unique African identity

Possibly because of the many forces of colonialism and its legacy that have warped African philosophy, it is today not a monolithic body of knowledge but essentially pluralistic in nature⁹. This plurality has resulted in a large proportion of the discourse in Africa being an extension of Western epistemology, with the consequence that Africa has, for most of its contemporary history, been a victim of European epistemological ethnocentrism¹⁰.

Higgs and Smith (2002) maintain that apart from being victims of slavery and colonialism Africans are also, nowadays, victims of neo-colonialism and that these factors are largely responsible for the impoverishment and marginalisation of Africa. The intellectual immersion in Eurocentric epistemologies has, according to these and other writers, crippled the African ability to understand or know themselves.

⁸ Ostrichised is my own neologism for explaining how members of the human species sometimes take on the habits of the largest of avian species by burying their heads in the sand when things are happening around them that they do not like, or are too afraid to take responsibility for.

⁹ Higgs, P. & Smith, J. African Philosophy: truth as African. In Higgs, P. & Smith, J. (2002).

¹⁰ Mudimbe, V. (1998). The invention of Africa. In: Higgs, P. & Smith, J. (Editors). (2002): 101

Added to this, the group experience of *apartheid* oppressiveness in South Africa has created a paradoxical situation in which black intellectuals possess a patriotism that is not simply innate but which also appears to be expected of them by the black majority Government. This has, to a large extent, silenced the voices of black intellectuals when it comes to providing negative critique of some of the Government's actions. Another factor that has contributed to the dampening of critical thinking amongst Africans in South Africa, results from affirmative action initiatives that have promoted promising young black intellectuals into professorships that have dampened their incentives and terminated the careers of these budding intellectuals because of their unpreparedness for the heavy administrative and managerial demands of such positions. These factors, according to Jansen (2004:19)¹¹ have created strata of intellectual mediocrity which leaves in its wake *"institutional cultures which are starved of the oxygen of public criticism and intellectual engagement"*.

So it is that these various and confounding paradoxes permeate and perpetuate the problems of defining an African identity and philosophy. And it is in this present that we see disturbing scars of a despotic past. However, there is another perspective on African philosophy that is opposed to the hybridised, predominantly Western version discussed above. This perspective maintains that philosophy is not primarily an academic discipline but more a general theory or idea that deals with important issues about life and human existence. It is thus a cultural activity which is not universal in character because there is no single philosophy applicable to all cultures¹².

Contemporary African philosophers provide additional geographical and race criteria to their perspectives of what constitutes African philosophy and this implies that only the contributions of Africans practising philosophy within the defined framework of the discipline and its historical traditions are considered valid¹³. Hountondji (2002:31)¹⁴ maintains that *"in Africa, colonial science is knowledge on Africa. The problem today is how to make it knowledge by Africans for their own collective promotion and*

¹¹ Jansen, Jonathan. (2004). **'Silent' black intellectuals cause worry**. Sunday Tribune. January 4, 2004: 19.

¹² Higgs, P. & Smith, J. African Philosophy: truth as African. In Higgs, P. & Smith, J. (2002).

¹³ Ibid

¹⁴ Hountondji, P.J. Knowledge appropriation in a postcolonial context. In: Odora Hopper, C.A. (Editor) (2002).

development.” Afrocentrism sees Africans as owners of knowledge and ideas, as well as owners of themselves¹⁵.

While I agree that the African history specifically warrants its own space within which to de-brief and reconstruct, I also believe that, within the reality of current circumstances in South Africa, where there has been fairly rapid and continuing integration of cultures on many levels a more natural and rapid enculturation is taking place that might impinge upon this process. Over the years of this country's struggle a people evolved that is multicultural, with its own unique cultural nuances but which calls itself South African and which has a profound attachment to Africa. It is as if the shattering of apartheid has unleashed a frenzied attempt at sharing and infusion of ideas and knowledge (so long imprisoned) about one another. It is this sharing and infusion of knowledge and ideas that provides a rich and fertile resource upon which new ideas and knowledge can be generated.

Higgs and Smith (2002:100)¹⁶ perhaps summarise best when they suggest that there are two conceptions of what African philosophy means, one, the academic concept, is that it is ‘a *rational critical activity*’ and the other, the traditional concept, is that “*African world views constitute an authentic African philosophy*”. Both of these views, I believe, should be considered in any future reconstruction of the African Occupational Therapy identity because together they will more closely approach the reality.

Born into a racist discriminatory system that perpetuates itself in those within it

Given the historical events described to this point, and which have impacted upon and moulded the development of occupational therapy in South Africa, it is clear that the profession's epistemological origins were immersed in the influences of colonialism's remnants and post-colonialism's emergence, in empiricism and other hegemonic Western ideologies of the time. Occupational therapy was also only a toddler when the political monster of apartheid was born, in which racism was the key overriding force.

¹⁵ Molefe, K. A. The Afrocentric idea. In: O'Toole, S. (2004).

¹⁶ Higgs, P. & Smith, J. African Philosophy: Truth as African. In Higgs, P. & Smith, J. (2002)

It would be naive to believe that none of these very powerful and osmotic influences, did not impact upon the content of, and approach to, how we designed our training curriculum, our attitudes as therapists and the way we practised. We were after all, in those days, only white. We were forced to 'treat' our 'patients' in separate localities, one for whites and one for other races (black, coloured and Asiatic). Let us remember that we also travelled in separate buses and compartments on trains, we used separate toilets and queues in public places. Thus, apart from our daily or less frequent *baaskapian*¹⁷ contacts and relationships with our domestic employees and gardeners, or, for those who worked in '*non-white*' occupational therapy departments, where contact and relationships were also *baaskapian*, we had virtually no contact with people of the oppressed races in this country.

It is possible that some colleagues of my vintage will, on reading this, argue that they may have had very meaningful and special relationships with their domestic employees and/or *non-white* '*patients*'. I do not deny this, I also had some very special relationships at this time, but I argue that it was impossible, given those circumstances, for any relationship between white and *non-white* to have been totally natural, unbiased and unaffected by these abnormal and inordinate positions of inordinate power that whites were placed in at the time. I argue that a totally natural relationship may only have been possible if one was actively involved in and part of the Black *struggle*¹⁸ for liberation, and not many of us were involved in that.

In addition to this most unnatural situation of separateness and abnormal relationships we were also aware of the differences in equipment, space and locality of the sites in which we 'treated' our 'patients', those for whites generally being far better equipped, more accessible and in better condition than those for the other races.

¹⁷ This neologism comes from the Afrikaans word '*baaskap*' which means dominance or mastery and which is derived from the word *baas* meaning master or boss, the term that white male employers expected their black employees, or any black person for that matter, to use when they were addressed. In this context it alludes, with few exceptions, to the generally unnatural relationship white people had with black and coloured or Asiatic people, in which the power was mostly perceived to be within the hands of the white person.

¹⁸ The term used by freedom fighters and anti-apartheid activists to describe their toil and war against the powers of apartheid

Postcard #5: Nonnies - little negatives

I recall as a student in Pretoria, when doing a clinical practical block at (what was then called) the H.F. Verwoerd Hospital's non-white Occupational Therapy Department, we referred to it as Nonnies. This word was derived from the 'non' part of the 'non-white' word, and then, using the Afrikaans diminutive structure, had an 'ie' added to it to turn it into an Anglo-Afrikaans hybrid and sweet sounding word that can best be translated as 'little nothings or little negatives'. I am convinced that whoever created this word did not for one moment think that the Afrikaans diminutive of the word 'non' would ultimately create a word that epitomised how apartheid perceived and treated those people of the oppressed races. It is only now in retrospect that I realise the significance of this, just how this monster of apartheid, like a sinister virus, infected us, often unwittingly, and how the resultant disease turned us into collaborators within the system.

The side-effects of this past still persist, albeit subconsciously, in the thinking of some white therapists today, and are exhibited in their covert allusions to the inferiority or inefficiency of the 'other' or the efficiency and/or adequacy of the past health system. These insinuations may be aimed at the training of occupational therapists in historically black universities (HBU's) or the current health care system which, conceived by its mostly black parents, has come through the usual bumps and thumps of childhood, will probably encounter some delinquency in its impending adolescence, but will hopefully turn into a much more acceptable and efficient adult than its elitist, inequitable and inaccessible predecessor. Some examples of this evident in my focus groups will be discussed below.

EXAMPLE 1:

The following is an extract from one of the Focus Group responses to the question: **'Do you believe that the role and scope of practice of occupational therapy has changed over the past 20 years?'** A is a young black therapist and lecturer who

trained in an HBU, while **B** is an older white therapist and lecturer who trained in the apartheid era at a HWU. Both are aware of where each trained.

A: The other thing that maybe I'd like to comment on... it's with the training of students in psychiatry... I know 20 years back I wasn't practising as an OT but... when I was taught as a student we were taught to use activities with psyche patient's and then we were more exposed to chronically and psychotic patients in the hospital but now because one is practising in private practice you hardly see those kind of people coming to your office (1)...people who are referred to you mainly are for depression...are for anxiety disorder... um.... there for stress management (2) and those kind of activities that we are taught in my training actually they are on a very low level for those kind of patients and (3).. you cannot (4) ... to some people doing (5) ...such (6)...some of these activities (7) ...it's like you get referral from (8)... a...a... company (9) when they bring their manager (10) or their editor (11) to come and see you and you have to do activities as an OT with them ...and ...it's ...it's quite challenging (12) and I think when you are just only exposed to psychoses and schizophrenic (13) and those kind ...it's quite challenging for students when they qualify and they have to deal with such...such people (alludes to 9, 10 and 11 above) ...and coming to think of appropriate activities ...I'm not saying we're not using activities (14) but it's more challenging (15) to come up with a relevant activities for those kind of people (16).

Comment 1:

A: makes some very relevant points i.e. that her psychiatric training tended to focus on teaching students therapeutic occupations for chronic institutionalised people with psychiatric problems (1) whereas now as a qualified therapist in her private practice she is seeing people with more acute problems who are not institutionalised (2). The implication is that her training did not prepare her adequately and that she graduated without an activity repertoire suitable for the type of clients she is now seeing (3).

Her fumbling with words (3, 4, 5, 6, 7, 8, 9) suggests her difficulty at expressing the frustrations caused by this and the mention of the company's, managers and editors (10,11) alludes to the level of patient seen, the repetition of the word challenging (12, 15) and the statement that she's nevertheless using activities (14) for the company managers and editors (16), convey the sense

that in spite of this lack of preparedness she has managed to turn the situation into a challenge and cope with it, to her credit and indicative of the adequacy of her training in teaching her how to adapt. This is also evident in her ability to adapt from treating chronic patients (13) to more acute ones (1&2).

B: But I want to differ from you (1)...to some extent (2) because I think it may be because how your training was (3).... but there are other training centres (4)...um... there are other training centres (5) who do teach the students to ... to be able to do activities with high level patients (6)... not necessarily psychotic, long-term chronics ...uh...you know... but also to work with high level patients (7) ... uh so it's not as if every (8)occupational therapist has got that problem (9)...I think there might be some (10) that have them but others (11)are well equipped (12) to ...to deal with that (13) ...ja.

Comment 2:

B's response is ironic in that she asks to differ from A (1) and (2) but repeats, in a different way, exactly what A has already said (see A1 above) i.e. that it is A's training (3) that does not adequately prepare her for treating the higher level psychiatric clients that she is seeing in her practice today.

B: ...But I want to differ from you (1)...□.to some extent (2) because I think it may be because how your training was (3)...□.but there are other training centres (4). □.um⊙... there are other training centres (5) who do teach the students to □... to be able to do activities with high-level patients (6)... □... not necessarily psychotic, long-term chronics (7) □...uh□you know...□ but also to work with high level patients (8) ...□.uh so it's not as if every (9) occupational therapist has got that problem (10)... □...I think there might be some (11) that have them but others (12) are well equipped to □...to deal with that (13) □...ja.

Comment 3:

However, on re-examining B's response more closely, we discover a classic example of 'othering': What was it about A's training (3) that made it different from other (4, 5 and 12) training? This 'otherness' is echoed in (9) where again it is emphasised that not every therapist

has A's problem. Those 'others' are well equipped (12) to deal with both chronic and acute, high level 'patients'. The numerous hesitations (□) throughout are indicative of how B is cautiously selecting her words. The conclusion thus that 'your training' (3) (i.e. A's), which took place at a HBU was different, and by implication inferior (5 & 6), to 'others' which alludes also to B's training, which took place at a HWU.

EXAMPLE 2:

The next example from another Focus group is also a response to the question: **Do you believe that the role and scope of practice of occupational therapy has changed over the past 20 years?** The comments are from two older white therapists who trained in the apartheid era. It is contextualised within a discussion around the problems younger therapists are picking up in public sector and community service work (echoes of example 1 above). The other person in the conversation, E, is a younger recently (post apartheid) qualified Indian Occupational Therapist.

C: But perhaps there is this discrepancy (1) now about what the demands are on an entry grade OT (2)...because I think that that's also changed over the years (3), I mean when I qualified (4) you went into a job which was quite defined and there were always people (5)... well I mean that didn't happen to you (refers to me, the researcher)¹⁹ (6) ...but I mean every situation I worked in that was so there were senior staff to manage the service (7) and to ...I mean but that wasn't true for everybody (8). Although it seems like the people that enter the working force now (9) are forced into taking this huge amount of responsibility (10) and fight the system (11).

Comment 4:

This (1) is referring to new graduates (2) and the discrepancy has changed (3) since C qualified (4). But as C correctly says, when she qualified in the apartheid era, hospitals were mainly geared

¹⁹ This allusion to the fact that I didn't have it so well, acknowledges the discrepancy in the allocation of resources to various regions in the apartheid days. Thus as already discussed in Chapter 4:67-68 the participant openly acknowledges that I, who then worked in KwaZulu-Natal (A stronghold of the Nationalist Governments opposition party) was at a disadvantage and was under-staffed by comparison with her who worked in a region with a strong Nationalist support base.

to treating white patients and there were thus fewer patients, and the leadership/hierarchy (7) and numbers of therapists to patients was better than it is today because of the greater numbers able to access rehab today. She acknowledges this wasn't true for all (6 and 8), referring to my situation in Natal where the OT services and infrastructure were vastly inferior to the Cape and Transvaal where the core (Parliament and Union Buildings) of nationalist power were situated. C now maintains that graduate OTs entering the work force today (9) have to take a much greater responsibility (10) and have to fight the system (11) referring to the new Health system.

She continues:

C: and of course the system (12) has got much more difficult (13) and much more complicated (14) to fight (15)...and you need to be mighty strong to fight it (16).

(RJ: Ja! Absolutely (17)).

Comment 5:

This second allusion to the new "system" (12) here is that it is much more complex, bigger and more powerful (13, 14, 15 & 16) and by implication worse than its predecessor where there were more therapists and a better infrastructure for personnel. Please note my emphatic agreement with C., which aligns me with her perceptions of the new system!

D: Another thing that's changed (1), I mean in the physical (2), and I don't know if we've really got hard core evidence (7) to say what we're doing is an effective job (3) treating a group (4) of hemis (5) versus one to one (6)...that needs to be looked at (7).

Comment 6:

D is referring (1) to the physical disability field of OT as opposed to the psychiatric field. She voices her doubt as to the efficacy (3) of occupational therapy in the current (post-apartheid) (1) health system because it has resulted in far more group 'treatment' (4) (in this case she is referring to stroke victims) (5) than the past where it was more a one therapist to one patient (6) situation. This, she feels, needs further investigation (7) to see if, in fact, the current situation of too many patients and too few therapists has resulted in a deterioration of quality of service (3).

E: Well I mean I think that's exactly the same for psyche (8)... yeah, I think it's absolutely the same...

Comment 7:

E concurs that the same i.e. more group treatment as opposed to one-on-one treatment, is true in the psychiatric field of OT as well.

C: (Interrupts) especially the size of the groups (9) that are being used in psychiatry they go beyond any therapeutic number (10) that we've ever seen. (11) **[RJ: Really, whew! (12)...]** and in fact there's no.... there's not a lot of evidence for *anything* that we do (13), we work on hearsay (14), we believe that it works, we don't actually know it works (15), because professionally we're not into proving that what we do is effective (16), because we...well our_story is because we're always battling the system (17), we've got too much to do, too many patients (18) (? Inaudible, but sounds like "we've got to sort it all out") and we don't do anything to protect ourselves. (19) ... (Some "mmm's" from the others) (20)

Comment 8:

C continues with the problems of the current Health System in which the shortage of OTs combined with the opening of the 'floodgates' for all to have rehabilitation, (9,10&18), has resulted in a kind of chaos in which neither the 'patient' (13,14, 15 & 16) nor the therapist (17, 18 and 19) benefits. Note again how the researcher expresses her amazement (12) and the others concur (20).

Vignette: #3: Testimonial: *I have known all the older (apartheid era) therapist/lecturers involved in these focus groups for many years. I trained with some of them, others have become special friends over the years, through a variety of work related circumstances such as examining together as external examiners, being on National OT related committees etcetera. So I feel I am in a position to say with informed confidence, that my friendship and acquaintance with them has left me with an impression of very committed, caring, non-racist individuals. I also perceive myself as being such. Thus what is noteworthy about the results of some of the above analysis is how the racist and elitist indoctrinations of apartheid have permeated our thinking so that we often unwittingly, still, reveal this contamination. There are obviously problems with the current Health System that need to be ironed out, but most important of all the system now provides a service for the thousands of South Africans whose previous access to it was very restricted, and when access was gained, it was to second-rate facilities.*

During the years that I was on the Council of the South African Association of Occupational Therapists (nearly 20 years from early 1970s to late 1980s) this Association was under constant pressure from external sources such as the World Federation of Occupational Therapists (WFOT) and Black South Africans who wanted the Association to stand up more aggressively against apartheid and take an active role in helping to dismantle it. The Association took a tacit stance of opposition to apartheid; however, the general feeling amongst Council members during that period was that the Association was not a political organisation and thus could not get involved in political issues.

In 1987 WFOT sent a delegation to South Africa to obtain first-hand information about the stance of SAAOT regarding apartheid. As vice president of the Association at the time I was part of the executive that planned and hosted this visit and thus personally had accurate information on it. The delegation reported (Claxton, 1998:3-4) that SAAOT was *“an active but competent group who need to develop strategies for better use of the potential political power they possess”*. They maintain that *“few (1) signs of discrimination by occupational therapists were found although (2) they were working in a system (3) that still condones apartheid. It became increasingly clear that in spite of (4) the political climate, South African occupational therapists ascribe to the same philosophy (5) as their colleagues in other countries²⁰”*.

[What is noteworthy here is the *double entendre* revealed in the word *few* (1): firstly, it is accusatory in implying that there were still some signs of discrimination observed by this delegation. However, the word also appears to be making an excuse for us by implying that in spite of the fact (2) that South African occupational therapists were working in an apartheid milieu (3 & 4) there were only a few signs of discrimination were found, and generally our worldview was much like that of our colleagues in other countries (5).]

This WFOT statement is a pretty accurate assessment of our stance at the time. It was impossible to work in such a system without being discriminatory because discrimination was legislated and thus, whether one wanted to or not, one was forced, by law, into

²⁰ Claxton, V. (1988). **Editorial: Summary of the report at the World Federation of Occupational Therapists**. South African Journal of Occupational Therapy, May: 3-4.

discriminating. However, it is also difficult not to believe that walking, talking, sleeping, working and living within this world every day and all day for years did not indoctrinate us into tacitly or openly supporting it.

Duncan (1999:5)²¹ courageously expresses her own personal views about being an occupational therapist in those times: *"I know that we worked hard and well to treat patients of all races to the best of our ability often under appalling conditions. What has worried me the most is my capacity for moral disengagement through apathy, inaction and silence, this despite my professional socialisation into the highest ideals of occupational therapy. I missed the mark of virtuous professional behaviour then"*.

In retrospect this disengaged stance could be considered a rather passive and easy way of evading our responsibility. However given the militant, oppressive and totalitarian nature of the government of the time it is highly likely that our Association would have been silenced through closure and the profession would have been even more marginalised than it was then. Certainly, much-needed posts for occupational therapists in government hospitals would possibly have been either frozen and /or closed once they had been vacated. It is thus debatable whether we would have survived to become the profession we have today had we done so.

Fanon²² refers to the damning impact that colonialism had on health care and the consequences that arose from the culturally inappropriate models of care which lead those who practiced them to complicity in racism and colonial terror. To avoid repeating this pattern it is essential for therapists who have trained under a Western epistemology to be constantly aware that the situated meaning of culture in their practice is an essential and core concept²³.

The constitution of both scientific and non-scientific knowledge is dependent on the ways in which people categorise, code, process and impute meaning to their experiences. Everybody possesses knowledge even when there are variations in the grounds for

²¹ Duncan, M. (1999). **Our bit of the calabash: Thoughts on transforming occupational therapy in South Africa**, 18th Vona du Toit Memorial Lecture. South African Journal of Occupational Therapy. Volume 29(2): 3-9.

²² Fanon, F. (1967). *The wretched of the earth*. Harmondsworth. Penguin.

²³ Algado, S. & Cardona, C. *The Return of the Corn men. An intervention project with a Mayan community of Guatemalan retornos*. In: Kronenberg, F. Algado, S. & Pollard, N. (Editors). (2005).

belief and the procedures for validation of knowledge. Knowledge emerges out of a complex process that involves social, situational and institutional factors. This process occurs on the basis of existing conceptual frameworks and procedures and is also affected by skills, orientations, experiences, interests, resources and patterns of social interaction. It involves ways in which we construe the world. It is constructive in that it incorporates previous ideas, beliefs and images and is simultaneously destructive of other possible frames of conceptualising and understanding. Knowledge is also never fully integrated or unified in terms of an underlying cultural logic of systems of classification²⁴.

As occupational therapists trained to practice primarily in South Africa, we cannot base almost our entire knowledge system upon one which itself is based upon the knowledge, occupations, views and values of a culture that is largely foreign to the majority of South Africans and were generated by a culture that is viewed as oppressive and thus also the cause of untold misery and suffering.

The exclusion of indigenous knowledge from the occupational therapy curriculum

Apart from the virtual exclusion of all indigenous knowledge from the process of the construction of the South African Occupational Therapy curriculum, we have also largely invalidated the African knowledge systems around human occupation and its particular role and significance within the African culture. The unique cultural constructs of occupation within African culture are virtually unknown to the majority of South African occupational therapists, and yet we daily provide a service for literally hundreds of Africans. And I am not referring to the tokenistic little activity assemblages of beadwork, mat work and pottery that many occupational therapy departments have within their repertoire of therapeutic activities. I mean the need for a recognition of the relativism, as opposed to absolutism, of social constructs, and a deep understanding of how occupation is construed and constructed within the African culture, more particularly, its relationship to health and wellness.

²⁴ Studley, John. (1998). **Dominant knowledge systems and local knowledge:** Forum On-Line Library. <http://www.mtmforum.org/resources/library/studj98ahtm>.

The significance of certain activities in the African cosmology may for example provide for rituals and taboos around them which have considerable significance for Africans. The same applies to the diversity of Indian cultures that currently constitute the South African population. For example in both Zulu and Hindu cultures there are similar taboos related to menstruating women and their not being allowed to work with certain foods during this time of the month. While women are largely responsible for the cultivation of vegetable gardens, only men and boys are allowed to work with cattle in most African cultures. The cattle, apart from the economic value they hold for their owner, also hold an enormous ritual value and significance as they form a link between the ancestors and their living descendents. It is thus that cattle become the most important animal of sacrifice on significant occasions such as at the death of an important member of society when a girl or boy reaches puberty or when there is a marriage²⁵. The slaughter thus becomes much more than simply a means of providing food for the guests at these times of mourning or celebration.

These examples are but a few of the many differences in the value and significance of various occupations within African and Indian cultures – occupations that may be role-bound, necessitate various rituals, carry specific meanings, and be tied to certain taboos and hence possess significance which is unique to that culture.

Western occupations versus African occupations

Even the Western classification of activities, commonly used by occupational therapists, into the broad categories of work, leisure/recreation and self-care activities differ amongst the various cultures of South Africa. For example, among African women employed in urban domestic jobs, an important source of leisure and recreation is to sit together, often on a grass verge or under the trees after a long day's work, and talk about the day, each other's children, their woes and joys or exchange snippets of gossip about their employers. Although some may, while doing this, also participate in activities such as hair braiding, needlework, and crochet or knitting, it is also quite acceptable to

²⁵ Krige, E.J. (1965). **The social system of the Zulus**. Shuter and Shooter, Pietermaritzburg. Although Krige's book is old and considerable enculturation has occurred since it was published in 1965 which has changed some of the value systems of Zulu people, it is still considered one of the most in-depth study's of the Zulu culture of its time and reveals many traditional beliefs and practices that still have their roots within the Zulu culture today.

simply sit and chatter. By Western classifications this would not be categorised as a leisure time activity because of the absence of actual activity, yet serves this purpose for those African ladies engaged in it.

For Indian women occupation in the kitchen and the shared activity of cooking, delighting in the combination of cooking their wonderful spicy culinary delights whilst sharing gossip and banter about each other and their local community, often serves a similar purpose. I wonder - would we classify this as a domestic activity or a leisure/recreational activity? African children, from an early age participate in work and domestic activities such as the boys assisting with herding and minding of cattle and goats whilst the girls assist in fetching wood and water and with other domestic chores such as caring for younger siblings. Often these activities may be combined with play activities or they might simply become the fantasy play that all children indulge in when “pretending” to be grown up.

Mkhize (1988)²⁶ maintains that, for example, during harvest time in KwaZulu (May to June), young rural girls have to engage in a series of work activities such as field labour, grain storage and pounding of the grain, which leaves them with little time for leisure and play activities or games.

Sub-Saharan African cultures have in fact used activities for therapeutic purposes for many centuries. Various forms of group “treatment”, rituals and ceremonies for the betterment of the whole group are used, reinforcing the concept of reintegration of the individual into the group. Artists were employed to create art forms such as music, dancing, masks and necklaces for use in rituals and to wear in order to ward off illness²⁷.

The use of dance and song is an integral part of Zulu life, both for the individual and the community as a whole as a means of maintaining psychological harmony and a sense of group solidarity. Most songs are accompanied by dance, or rhythmic movement and these modes of expression usually form an important part of ceremonial events. Dancing begins at an early age and small children may include dancing in games in which young boys and girls play. In early traditional Zulu life dancing was an important part of

²⁶ Mkhize, F.W. (1988). **Classification of rural play activities**. Mini dissertation as part of the B.Occupational Therapy Degree, University of Durban-Westville, Durban.

²⁷ Krige, E.J. Music, Dancing and Song. In: Krige, E.J (1965) *The Social System of the Zulus*.

courting, and love dances or dancing competitions were an important feature of recreational activities for young people.

Today a lot of occupational therapists working in areas where they may see a lot of African people, do use music and singing as therapeutic activities but they rarely include the dancing that is so integral to it in indigenous cultures and few, if any, have explored the ways in which song and dance are used as forms of communication and recreation in African societies.

Traditionally Zulu folklore was shared in the form of oral stories, many of which had a moral attached, but for the most part storytelling was, and still is, performed for the amusement and recreation of the listeners. This practice is also common to the Xhosa, Basotho and Thonga peoples, and many of the stories derive from the ancient store of tales of the Khoisan peoples²⁸. Unfortunately, today the sharing of the old folk tales is less common in the urban and suburban milieux but in modernised form the story, whether it is about one's own children or news of mutual friends or general gossip still provides an important source of recreation and amusement.

Luger *et al* in their study of "Time Off" Occupations for Domestic Workers²⁹ reveal how domestic workers participating in this study would frequently inform the researchers that they did nothing with their 'time off' when in fact they were involved in a variety of occupations. These researchers also reveal how these "time off" occupations were closely linked to the central African concept of *ubuntu*. This philosophical concept is deeply entrenched in African culture and literally means '*I am who I am through others*' and is intricately interwoven into many of the occupations engaged in. The study by Luger reveals, for example, how this is the ideal set within Nguni cultural groups for social relationships and one that connects them to their heritage despite being in an alien environment. Thus, occupations pursued in isolation such as watching television were described as 'nothing', whilst sharing this occupation with a friend and being able to communicate about it together was perceived as enjoyable and valuable.

²⁸ Ibid p 345

²⁹ Luger, R. Sherry, K. Vilikazi, B. Wonnacott, H. Galvaan, R. (2003). **A struggle for identity: Domestic workers, ubuntu and "time off" occupations.** South African Journal of Occupational Therapy. Volume 33(2): 11-14.

Traditional indigenous occupations

Early traditional Zulu industry involved the manufacture of utensils that were mostly used for domestic purposes. Pottery vessels were manufactured for cooking, storing foodstuffs such as beer and for washing. Woodcarving was used to create the bowls used in milking, making headrests for sleeping and spoons for cooking. In parts of North Africa the now highly sought after African ceremonial masks were also an important part of this industry. Today the more modern African woodcarving industry has taken advantage of the burgeoning tourism trade and it is difficult not to be delighted by the manner in which the character of a specific wild animal is so explicitly captured in the carved figures we see being sold along the roadside in many rural areas in Africa.

Weaving and basketry are also an important part of traditional industry and are employed in the making of sleeping mats, beer sieves, eating mats and baskets. String (umJiba) for thatching roofs is also plaited from grass. This is another industry that has been exploited as a source of income for many rural and semi-rural people.

Beadwork originated as a convention of the courting process in which young women would use beads to make ornaments and tokens to give to the man they admired. The colours in the beads conveyed distinct messages; for example, white was a symbol of love, green beads signified sickness or feeling unwell, while red beads indicated sadness and longing as in the red eyes of crying³⁰. Many of the craft objects such as pots and woodwork are often elaborately decorated either by using different coloured clays for pots or in woodwork burning on designs and patterns or even inlaying bone and ivory. Traditionally, most of these industries were gender-based. Thus pottery, weaving and basketry were women's industries while woodwork, ironwork and anything to do with cattle were men's work.

What is interesting about the activities of daily living of many of the African cultures, and in this instance my frame of reference is the Zulu culture, is that there is not the rigid

³⁰ Krige, E. (1965)

distinction between the various activities of daily living that exist in Western-Eurocentric cultures i.e. work, leisure/recreation/play and self care, with many sub-categories defined under each of these broad categories. It seems that activities of daily life for rural African cultures are far more intertwined and without absolute distinction so that, for example, in the process of going to fetch wood and water for the domestic chores of the home (a work activity) the women and children will tell stories or sing *en route* (recreational) and when they reach the river the women may well also use the time to wash and refresh themselves (self care) while the children swim and play in the water.

The rigid categorisation of activities of daily life that our Western frame of reference imposes upon occupational therapy has resulted in us being unable, rather than unwilling, to relate to or grasp the fact that African cultures have a different perception and concept of occupation. Thus it is that South African occupational therapists have often experienced the process in which we have imposed our Western occupational classifications upon African occupation as one rather like trying to put a square peg in a round hole.

It is of significance that 33 years ago almost the entire December 1972 volume of the South African Journal of Occupational Therapy³¹ almost the entire journal was dedicated to issues related to indigenous knowledge. However, typically for those times, of the three authors contributing to this issue only one was himself African, the other two being European/white. The respective articles were '*The Ideas of Health and Disease: A Re-Examination of the Theory of Forces*' by Dr N.C. Manganyi; '*The Ability of Africans*' authored by the famous Dr Simon Biesheuvel (who produced one of the most rigorous critiques of the use of existing intelligence tests and the inadequacy of their application to Africans³²), and the last was titled '*African Family Life*' by a Dr E. Hellman. Ironically Dr Manganyi³³ himself refers to another European, Tempels (1959) (unreferenced), who apparently published a provocative monograph on 'Bantu Philosophy' which Manganyi maintains provides a definitive formulation of African cosmological ideas. This publication is typical of what Oyèrónké Oyewùmi³⁴ describes as the hegemony of the

³¹ SAJOT Volume 3 No. 2 December 1972.

³² Dubow, Saul. Mental testing and the understanding of the 'native' mind. In: Dubow, S. (1995).

³³ Manganyi, N.C (1972). **African ideas of health and disease**. South African Journal of Occupational Therapy. Volume 3 (2): 7-9.

³⁴ Oyewùmi, Oyèrónké. The white women's burden: African women in Western feminist discourse. In Oyewùmi, Oyèrónké. (2003). (Editor).

West and monopoly of scholarship on Africa by white men, which, she maintains, is largely responsible for the many misrepresentations of African culture.

While sundry articles related to indigenous knowledge have since appeared in the South African Journal of Occupational Therapy these are scarce and again mostly written by people of races other than African.

Race, ethnicity and diversity

As a result of South Africa's unique history, which was embedded and embodied in racism, it would be neglectful not to conclude this chapter with a brief discussion on race, ethnicity and diversity and how these have influenced the development of occupational therapy in Africa.

The word 'race' within the South African context is multifaceted and loaded and conjures up multiple perspectives, most of which are negative. It carries with it a burdened historical context that should make members of the white races who were part of apartheid, feel a sense of shame and those of other races feel a sense of anger, insult and outrage. Apart from being used as a reign of unspeakable injustice against groups of people based upon their race, apartheid drove such wedges between the various race groups that it destroyed opportunities for getting-to-know, understand and respect each other's diversity. Instead it fostered discrimination based upon myths, stereotypes, suspicion, fear and mistrust. Race is a dirty word in this country. South Africans either avoid it by using other terms such as culture and ethnicity, or they use it to perpetuate the angry and discriminatory discourse its apartheid parents spawned.

Even the issue of who is or is not an African is freighted with bitterness and anger and formulations of identity are based upon race. I was born in Africa, my paternal forefathers colonised South Africa over 300 years ago, I can identify many of its indigenous plants, animals and birds, my white skin shows the ravages of many years of exposure to the hot African sun. I speak some of the indigenous languages including Zulu and Afrikaans, not expertly, but at least with reasonable fluency. My soul has been sculpted by the sights, sounds, smells and tastes of Africa. I am passionate about my

land and continent, my body and mind go into withdrawal when I am away from it for too long, and I have no desire to live anywhere else on the globe. So what does that make me?

Sefularo³⁵ maintains that one cannot be a real South African if one continues viewing this country, its government and institutions from a Western perspective or if there is a contradiction between one's claims and one's actions, for example, maintaining one is patriotic and African but continuing to see South Africa through foreign eyes.

Makgoba³⁶, when contextualising racism in South Africa describes it as '*a socially constructed phenomenon with no biological basis [comprised of] a complex system of symbols and meanings that continues to modify over time as a consequence of both societal changes and political struggles*'. In his own racial construction he maintains that there are still some white males in South Africa that continue to want to monopolise and dictate the definition and appropriate meaning of racism and as such they deny the collective body of African experiences of racism.

Cena *et al* (2002)³⁷ argue that, rather than effacing the issue of race by silence and evasion, occupational therapy literature should present an accurate representation of '*people of colour*', which would not only raise the awareness of the character of our practice but would also allow for investigation of service inequalities. There are two important implications in this argument: the first is that not enough attention and research are devoted to race groups other than White in the United States Occupational therapy agenda, and the second is that there are inequalities of service for races "*of colour*" when compared to services for the dominant Caucasian races of the USA. So it is evident that the perpetuation of discriminatory practices based upon race, occur beyond the South African borders.

The ethnocentricity of the white, middle class North American norms and values entrenched in occupational therapy in the United States has led to a great deal of criticism from people of other races and sociological backgrounds as to the lack of

³⁵ Sefularo, M. (2005). **Are you truly African?** Sunday Times, May 29: 21.

³⁶ Makgoba, M. (2005). **Wrath of dethroned white males**; an analysis and comment. In: The Mail and Guardian, March 24th to 31st: 23.

³⁷ Cena, L. McGruder, J. & Tomlin, G. (2002). **Representations of Race, Ethnicity, and Social Class in Case Examples**. American Journal of Occupational Therapy. Volume 56(2): 130-139.

resonance of this orientation with their particular norms and values³⁸. Cenna *et al*'s study of the language used to describe race in 24 years of American Journals of Occupational Therapy revealed that the nation's language does not reflect the nation's diversity, either because diversity went unreported or because diverse clients and participants were not included for description. They conclude that while constructs of race are sensitive they are important to include in studies because they provide a basis for evaluation of health care access and outcomes across races to ensure equality of services³⁹. I would add to this assertion that more attention to reporting on relevant issues of diversity would enhance the ability of occupational therapists to provide more effective services better tailored to meet the diverse needs of those they serve. An analysis of the article content of the South African Journal of Occupational Therapy (SAJOT) over the past three years revealed similar findings⁴⁰.

This chapter has attempted to demonstrate how, and why, the inclusion into the occupational therapy curriculum of adequate aspects of African indigenous knowledge and knowledge of race and cultural groups other than white Eurocentric knowledge in South Africa is absolutely crucial. It is crucial because it will neutralise the existing hegemony of Western knowledge within our curriculum and provides a challenging platform for the interchange of knowledge amongst the diversity of race and cultural groups of occupational therapists that we train in South Africa and that occupational therapists are likely to work with in the course of their daily practice. So doing will not broaden the understanding and respect of one colleague for the other but also that of therapists towards those they are trained to serve, which must, in turn, assure a far greater likelihood for them of achieving optimal quality of life.

The abnormal and pathological emphasis that apartheid placed upon diversity turned it into a monster rather than a wonderful resource in which we could all share and drink in the abundance that such diversity provides. It is this diversity that gives our country its uniqueness and richness: the sounds, smells and created by the multifarious South African peoples in their diversity transcend the clichéd rainbow - they are rather a symphony, passionate and deep, that reverberates through the day to day lives and discourses of each one of us, changing and moulding us as we listen to and soak up its music. The following chapter will particularly explore the dynamics of power and occupational therapy discourse in the context of this diversity and history.

³⁸ Ibid

³⁹ Ibid

⁴⁰ Kamadu, A. Naidu, D. Pillay, D. & Ramnaruthan, R. (2000). **A content analysis of the South African Journal of Occupational Therapy: Phase 1**. Mini dissertation in partial fulfilment of the B.Occupational Therapy Degree. University of Durban-Westville. Durban.

CHAPTER EIGHT

The Dynamics of Discourse, Power and Occupational Diversity

Route map: The purpose of this chapter is to draw together the particular forces that have had, and still may have, an effect upon the unfolding of occupational therapy as a profession and the development of its knowledge in South Africa. It explores power and how it has worked on and through the profession and it particularly looks at cultural and racial diversity and how the imposition of a Western worldview of occupation and health may have specifically impacted upon occupational therapy's development within South Africa

Vignette #5: Speaking across barriers "It has often surprised me how difficult it is to speak across colour barriers, to people who do not understand your reality. Communication barriers arise when one does not recognise the other's experience as authentic" (Namhla Mniki, 2004:27)¹

Introduction

Occupational therapy has persistently and rightfully acknowledged the importance of culture in influencing the values and attitudes attached to occupation, quality of life, health, disability, illness and wellness [Hasselkus and Rosa 1997; Wilcock 1998; Kielhofner 2002; McGruder 2003; Awaad, 2003; Bonder *et al*, 2004; Lorenzo 2004; Dickie 2004; Watson and Fourie 2004; and Iwama 2003, 2004, 2005a and 2005b]. International recognition of the link between meaningful participation in daily life occupations and health and wellness is growing but the profession has failed to be proactive and adequately reflect on the universal perceptions of this link and how many other professions and groups are now starting to jump on this bandwagon and poach on occupational therapy's territory.

Iwama (2003:584)² maintains that occupational therapy in its current construction may not necessarily be as meaningful and effective towards human health and wellness as

¹ Mniki, Namhla. (2004). **Black in a white world**. Comment & Analysis. The Mail & Guardian, November 12 to 18: 2004.

² Iwama, M. (2003). **Towards culturally relevant epistemologies in occupational therapy**. American Journal of Occupational Therapy. Volume 57(5): 582-588.

we thought and may in fact, even be counterproductive and oppressive to those who perceive, construct and live their realities according to different belief and value patterns and world views. He cites Asia, which constitutes almost half the world's population, as an example in which the construction of knowledge and values and the link between occupation and wellness is different and considered "*problematically ethnocentric*". Using the Japanese language as an example, he maintains that there is "*no such concept in Japanese that captures the conceptual meaning that Westerners ascribe to occupation and its link to wellness and wellbeing*" (Iwama, 2003:583). He maintains that this is because Japanese socially do not construct the word 'doing' with the same intrinsic meaning as does the West.

Looking at discourse in occupational therapy through a Foucauldian lens

Foucault perceived discourses as knowledges and these knowledges as collectively forming disciplines (professions), particularly the disciplines of the human sciences (McHoul and Grace, 2000)³. He defines discourse as the group of statements that belong to a single system (e.g. discipline or profession) or formation⁴. It consists of a constellation of statements for which a group of conditions or existence are defined, "*it is, from beginning to end, historical - a fragment of history, a unity and discontinuity in history itself, posing the problems of its own limits, its divisions, transformations, the specific modes of its temporality rather than its sudden irruption in the midst of the complicities of time*" (Foucault, 2003:131)⁵.

Foucault sets out various criteria by which to study discourse. Any discourse may be seen to form a unity and possess a number of fairly easily identifiable components that he refers to as objects i.e. the things discourses study or produce. Operations are the methods and techniques or ways of treating these objects, and a mode of statement. Concepts are terms and ideas routinely found in a discipline/profession and which constitute its unique language, and theoretical options are the various assumptions, theories and even hypotheses available within each discipline/profession⁶. Thus, in occupational therapy's discourse, it is important to trace its succession from the earlier

³ McHoul, A. & Grace, W. Discourse. In: McHoul, A. & Grace, W. (Editors). (2000).

⁴ Foucault, M. The description of statements. In: Foucault, M. (2003).

⁵ ibid

⁶ McHoul, A and Grace W. Discourse. In: McHoul, A. & Grace, W. (Editors). (2000).

period of its history in which it became so interwoven with the discourse of the medical model and to analyse how the concepts and theoretical options of each have become incompatible with one another⁷.

Foucault posits the transcendental nature of discourse, suggesting that, while it has an absolute centre or foundation, this is never reached or regained and each successive historical stage of the discipline can only approximate it. Hence, specific discourses cannot be observed as discourses in general (a global entity) because their histories are quite distinct. Both the historical implications and the diversity of the South African context from a cultural, racial and ethnic perspective, necessitate that the various discourses that affect and are affected by occupational therapy in this country need to be explored to discover their effect upon the development of a particular South African identity for the profession.

Relative to this, Foucault also maintains that the boundaries of discourse may alter or mutate or the language of the discourse may begin to operate differently⁸ thus, for example, in occupational therapy we have shifted focus and terminology from *symptoms* to *performance components* and from *illness* to *wellness*. The doing of occupation is now perceived as contributing to the actual being and becoming⁹ of the individual, whereas, in the profession's early years, the *doing* of occupation was perceived largely as a curative medium that improved the function of, for example, poor concentration, weak muscles and limited joint range.

Another important Foucauldian concept, that of the hierarchical transformations and interdependence which may occur in discourses in which one discourse may assume a position of supremacy over another¹⁰, throws light on the hegemonic influence of medical model over occupational therapy discourse. Thus it was that the discourses of the medical profession held supremacy over those of the allied health professions. The fact that our paternalistic forefathers in the South African Medical and Dental Council degraded us to being '*supplementary*' health professions by testifies to this.

⁷ Ibid

⁸ Ibid

⁹ Wilcock, A. (1999). **Reflections on doing, being and becoming**. Australian Occupational Therapy Journal. Volume 46: 1-11.

¹⁰ McHoul, A. & Grace, W. Discourse. In: McHoul, A. & Grace, W. (Editors). (2000).

Discourse is thus not simply a means of expression or accomplishment by human subjects, but rather it forms the discursive rules or criteria (conditions) that set up specific positions or places from which the subjects can achieve shape and form¹¹ as, for example, “patients”, “schizophrenics,” “mentally retarded” “cripples” and “abnormals”. Discourse, then, is a way of specifying what counts in knowledge and power rather than their truth, a recurrent pattern of language (in this context, related to historical changes in perceptions and representations around health and disability¹²) that shapes and reflects a profession’s intellectual commitments because it is the medium through which practices are constituted¹³.

A rights-based discourse recognises that social structures are products of discourse, occurring in language and within social interaction. But social structures do not rest upon solid foundations. They are rather contingent and invented and, as such, open to change, to local reading and to reinvention. Thus it is that one has, on the one hand, the orthodox discursive practices that constitute the construction of disabled people as a distinct social group, similar to the discriminatory grouping of blacks and gays¹⁴, and which associate disabled people with insulting or oppressive and derogatory terms such as crippled, unfortunate, flawed, limited, abnormal and dependent. On the other hand, disabled activists are challenging and overturning existentialist notions of normality and advocating the destruction of disabling societal structures that label people in this way.

Armer¹⁵, in his discussion about what constitutes normality, maintains that language may serve to obscure rather than enlighten. Modernity has appropriated for itself and uses the medium of normality to create disability. Once ‘normality’ has been established the concept ‘abnormality’ is a logical progression from there. And while the origins of abnormality were intended to signify deviations above or below the norm, current applications of the word are associated with inferiority and sub-normality.

¹¹ Ibid: 48

¹² Mercer, G. From critique to practice: Emancipatory disability research. In: Barnes, C. & Mercer, G. (Editors). (2004).

¹³ Hooper, B. & Wood, W. (2002). **Pragmatism and structuralism in occupational therapy: The long conversation.** American Journal of Occupational Therapy. Volume 56(1): 40-50.

¹⁴ Watson, N. The dialectics of disability: a social model for the 21st Century? In: Barnes, C. & Mercer, G. (Editors). (2004).

¹⁵ Armer, B. In search of a social model of disability: Marxism, normality and culture. In: Barnes, C. & Mercer, G. (Editors). (2004).

In the study of the epistemology of a discipline/profession, the laying of emphasis on discourse shifts the focus from particular individuals and institutions to the function of language within communities of interlocutors¹⁶. This enriches the conceptual resources available for historical analysis. In the context of occupational therapy, it is concerned with the language of occupation and how the individual's participation in occupation influences their health and well-being. What are the socio-political processes and their discourses that highlight certain perspectives and conceptions of occupation and health whilst suppressing others?

Some examples from the data

The following extracts from the data are used to demonstrate some of the mutations within contemporary occupational therapy discourse and how these also reflect the influences of the past upon contemporary discourse. The data was extracted from responses from the resonance groups¹⁷.

Respondent 2: *My overall comment is that Annexure 1 [commenting on the findings from my analysis of the SAQA submissions¹⁸] is using terminology that is entrenched in the medical model (1). Terminology such as "treatment", physical and/or psychiatric disorder", "patient population" (2) use of terminology such as "living environment" or "context of the client" would be more suited to the social and developmental models (3) and still be appropriate for the medical model. (4) OT's are working outside the health sector more and more (5)*

¹⁶ Grauman, C. & Gergen, K. (1996). Psychological discourses in historical context: An Introduction. In: Grauman, C. & Gergen, K. (1996).

¹⁷ Refer back to Chapter 2 where the complete details of data gathering and analysis are represented. Briefly to recap, the set of data represented here was the third set collected. The first set consisted of an analysis of all the occupational therapy training university's submissions to the South African Qualifications Authority (SAQA) in which they set out their training outcomes and the desired terminal competencies of the graduating learner. The second consisted of an analysis of four focus groups with therapists and lecturers, held in four provinces in which the core questions looked at change within the profession; clinical reasoning and competence; unique characteristics of South African OTs and whether current methods of assessing competencies are adequate. The final analyses of these two sets of data were then sent to a group (resonance group) of clinicians and lecturers for their feedback comments on the findings from these two sets of data.

¹⁸ Refer back to Chapter 2 pages 23, 24, 38.

Comment 1: The respondent is referring to the terminology used within the profile of occupational therapy competencies which was compiled by the researcher from the SAQA submissions i.e. data sets 1 and 2 (see page 19).

In this the transcendental nature of discourse is demonstrated by the respondent's reference to the entrenchment of medical model terminology within the described competencies (1) & (2) but then the suggestion that today a more appropriate and suitable terminology should be included follows in (3). The ability for the boundaries of discourse to mutate and operate differently is also evident in the differences between what the respondent perceives as being the discourse of the medical model infusing the document (2) and what is proposed as the more appropriate discourse of the social/developmental model (3), which will accommodate the profession's move away from the medical model (5). Finally, the fluctuating hierarchical transformation and interdependence seen in the respondent's initial criticism of the use of too much medical model terminology, suggesting more social and developmental model terminology but still, almost apologetically, suggesting that this new discourse might still be appropriate to the old medical model (4).

Respondent 7: *I know that's what you got from everyone (1) (i.e. referring to content of summary) but the medical model still shines through (2) will you adapt this or is it as it stands (3)? NB (4) Service development doesn't come through strong enough (5). Training of workers and care providers (6) needs its own (7) point. Empowerment of individual/enabling occupation (8) must be emphasized (9).*

Comment 2: Similarly, this respondent refers to the presence of medical model terminology (2) and is so convinced of this that she suggests all other respondents (1) must have come to a similar conclusion. Her concern extends into her interrogatively framed suggestion that this should be changed (adapted) (3) She goes on to express concern (4) about the underplaying of a distinctive historical change (service development) (5) and the need to train people other than 'patients' (6), and the use of new social/developmental model terminology (8) demonstrates again the transcendental nature

and mutations of the boundaries of discourse within the profession of occupational therapy at this time in its history. These changes are obviously perceived as being particularly important to the respondent as demonstrated in (4), (7) and (9).

Respondent 1: [responding to one of the terminal competencies of graduating OT as the ability to apply standardised and non-standardised tests to assess individuals in need of OT] ...same concern... treatment/ intervention is only one side of the coin (1)... The other is our increasing role in PHC (**primary health care**) at a preventative/ promotive level (2) and we need to be putting considerable effort into this domain (3)... The profession (4) has got tunnel vision (5) in wanting to “fix” things (6) instead of recognising (7) that we have lots to offer through occupation to public health by preventing at risk groups from needing “fixing” in the long run. (8) Our language should therefore reflect this (9) range of contributions (10) by deliberately being inclusive (11) e.g. “comprehensive OT” which means, in PHC speak, prevention/ promotion remedial/ therapeutic and rehab etc (12). This is my language (13) but obviously the profession needs to debate this (14).

Comment 3:

The “same concern” in (1) refers to her preceding comments in which she expresses concern about the “medicspeak” used throughout the document. The rest of (1) again demonstrates the respondent’s awareness of the changing discourse within the profession and the need to reflect this more clearly (2) and (3). Her frustration and irritation alienates her from her profession, which now becomes “the profession”(4) and which she disparagingly sees as being caught in a blinkered (5) world that is still caught up with the medical model’s preoccupation with curing (6) rather than preventing. (8) The alterations and mutations in the boundaries of occupational therapy discourse are evident in comments (2), (3), (8) and the expressed urgency for occupational therapists to recognise (7) their emerging roles (8) and use a language which is less paternalistically (hierarchically) influenced, but rather representative of the more inclusive language of the current health care ethos (11) and (12), an example of which is her own invention of the term “comprehensive OT” (13) to include all the new concepts within this new discourse

(12), which she suggests that it should be taken forward into debate by the profession (14).

It is evident from this brief exploration of some of the data, that the discourse of occupational therapy today is still deeply influenced by that of discourse of the medical model. But it demonstrates equally that the boundaries of our discourse are shifting, causing it to change and operate in ways more appropriate to our unique role. Furthermore, it shows the transcendental nature of our discourse in that, although it has altered during the successive historical periods through which it has passed, its absolute centre or foundation has not been entirely actualised or regained in the process.

Foucault's conception of discourse provides a useful perspective from which to understand the role of power in the production of knowledge within disciplines (professions). This includes the production of self-knowledge and identity as a discipline, which I will cover in more detail in the final part of this thesis. Foucault identified an essential link between power relations and truth, and how power relations had the capacity to produce the truths we live by¹⁹. Inherent in discourse is the often subtle evidence of power relationships regulating the behaviours of its members that emerge in every human culture. The discourses we produce within our professions thus become the truths we believe in and these in turn are reflective of the sources of power behind them. The power of the medical model thus appears still to shine through quite strongly in the discourse of South African occupational therapists. Foucault further maintains that it is not possible to dissociate the development of the various branches of knowledge of the human sciences from the exercise of power²⁰.

In its construction of the truth, the medical model decides on matters that define humanity and affect humanity in general. Medical disciplines, through sovereignty over this knowledge and their role in the origins of many of the '*supplementary*' disciplines, have succeeded in persuading or compelling many of these disciplines to believe in their truth at the expense of some unknowable truth²¹.

¹⁹ McHoul, A. & Grace, W. Power. In: McHoul, A. & Grace, W. (Editors). (2000).

²⁰ Foucault M. (1995). Strategies of Power. In: Kvale, S. (Editor). (1995).

²¹ Fillingham, L.A. (1993). **Foucault for beginners**. Writers and Readers Publishing Inc. New York.

Control and power within the therapeutic relationship using an ethnographic example

Since the eighteenth century, society and the human sciences have carefully defined the difference between normal and abnormal and have used these designations in order to regulate behaviour. Foucault perceives power as a strategy, rather than arising from appropriation and deployment by a subject or person. It is appropriated and deployed as manoeuvres, tactics and techniques. It is not imposed over the powerless; rather it invests them and is transmitted through them²².

The power of the therapist over the 'patient'

In his thesis “(Re)positioning the powerful expert and the sick person: the case of communication pathology” Pillay (2003)²³ explores the relationship of expertise and power between practitioner and patient and how social, political and cultural factors have been central to the development of practitioners in communication pathology in South Africa. He refers to the biographical identities of the ‘practitioner’ and ‘patient’ and uses the word ‘biographical’ to refer specifically to the core, essential or primary features of either the practitioner or the patient as they have been made to exist within what he refers to as the *clinical moment*. In each biography, there are written and unwritten ideological laws determining how each relates to the other, constituting what is essentially referred to as the professional relationship. Furthermore, Pillay maintains that the dominant biography of the practitioner is that of ‘powerful expert’ and that of the patient is that of ‘sick person’²⁴.

Pillay²⁵ suggests that the ideological positions that develop the powerful expert (practitioner) are:

- Further establishing the existence of *occupational disorders*²⁶.

²² Smart, B. Subjects of power, objects of knowledge. In: Smart, B. (2004)

²³ Pillay, M. (2003). **(Re)positioning the powerful expert and the sick person: The case of communication pathology**. Dissertation submitted in fulfilment of the requirement of the degree Doctorate of Education through the School of Educational Studies at the University of Durban-Westville. Durban.

²⁴ Ibid

²⁵ Ibid

²⁶ I have replaced Pillay's use of speech pathology terminology with occupational therapy terminology (in italics) to reveal how his argument also applies to occupational therapy.

- Extending the definition, organisation, classification and rating of *occupational disorders* (or people with physical and mental disabilities).
- Declaring the development of effective treatment methodologies for *occupational disorders*.

Completing the equation are the ideological-practical positions that contribute towards the 'sick person' (patient) in the clinical moment, which are:

- A specialist focus of practice (*specialists in human occupation and its effects on health and wellness*).
- A biological metaphor of the patient (person = biological; person + disorder = biological; disorder = biological) (*OT is more concerned with person as totality which includes psyche, soma and soul or spirit is but frequently pulled into medical model thinking where biological aspects are dominant*).
- The use of deficit theories (imperfection being the key issue within this perspective) for example: '*mentally retarded*'.
- Dis²⁷-othering: others are outside of the politically, socially and culturally dominant group, a necessary pre-requisite for those in power because without the other they cannot define their power, pathologising others renders them lesser than us, which relates to how we *dis* others.
- Essentialism: defining and classifying various *occupational disorders*, use of standardised tests according to the ideological-practical position of the discipline at the time.
- Reductionism: related to the empiricist and positivist ideals of the medical model and other scientific approaches, the piecemeal handling of segments of a problem reducing the totality of a person to symptoms and compartments.

It is quite tenable that Pillay's delineation of practitioner/'patient' relations also applies at least partially to occupational therapy, given our similar histories in this country and the influence of the medical model discourse as a foundation for our knowledge²⁸ and epistemological base.

²⁷ To 'dis' is an American colloquialism used to refer to disrespectful behaviour.

²⁸ In Chapter 4, the very strong historical influences of medicine and the medical model upon the profession are explored. Earlier on in this Chapter it is revealed how, although this situation is changing, it still has an influence upon the discourse of the profession today.

Pillay reveals the constant possibility of, and opportunity for, the practitioner to exercise influence over the '*patient*'. I am convinced that for the most part, the intentions of occupational therapists when working with those in need of their services, are not focused on exercising power or control over the '*patient*'. What operates is a far more subtle, deceptive and ingrained sense of power which was born, and has become embedded, as a result of those unique social, political, cultural and historical influences determining the development of the profession in South Africa. And because of this, it may be exercised unwittingly and requires of its wielder constant, sensitive awareness and vigilance to counteract it when it surfaces.

The '*patient*' becomes the subject and object of our knowledge and the gathering, analysis and interpretation of this knowledge is deeply influenced by the manner in which occupational therapy in South Africa has institutionalised the scientific discourse, and particularly medical model discourse, throughout its development as a profession. Foucault²⁹ maintains that it is the analysis of discursive practices, of status, conditions of exercise, functioning and this institutionalisation of scientific discourse that is important for a clearer understanding of the articulation between scientific discourse and political practice. And underlying all this is the issue of power associated with, and attached to, discourse.

The power of '*patient*' over therapist

Power is never one-sided; even those in positions of so-called 'weakness' can make use of various tactics to attempt to gain control over their lives. This is particularly relevant in developing an understanding of those whom occupational therapy serves, many of whom have become seriously functionally 'weakened' because of the physical and psychological insults (through trauma or disease) to their bodies and minds, which are exacerbated by the insensitive and oppressive discourses created by non-disabled society about those with physical or psychological impairments.

²⁹ Smart, B. Subjects of power, objects of knowledge. In: Smart, B. (2004).

Before commencing a discussion on this aspect of power, I will share with you an evocative narrative as a means of illustrating the interplay of power between therapist, assistant³⁰ and 'patient'.

Postcard # 6: A Power Trilogy:

In the early 1970s, after qualifying as an occupational therapist, I worked at a large beachfront hospital in Durban. We had an assistant, Rebecca³¹, a proud and upright lady who over the years became a close friend and confidante. There was a young man called Johnny³² who was severely disabled as a result of a head injury sustained in a motor vehicle accident attending occupational therapy. He came to OT every day and had a routine of working in our woodwork shop, socialising with others, attending therapy and attending physiotherapy in the afternoon. He lived at home, his mother worked and our service provided a form of institutionalised therapy that gave her the freedom to know he was in safe hands. For those of us working with Johnny, consensus was that our interventions did little other than alleviate his boredom and provide some respite for his mother.

One afternoon I came into the main therapy area of the occupational therapy department to find Rebecca looking very distressed and Johnny laughing. "What's the matter, Becky?" I asked. "Johnny has called me a bloody kaffir³³, nkosizana³⁴" she replied. "Unless you apologise to Rebecca now Johnny, I will send you to physiotherapy without having occupational therapy!" I said, knowing how much he enjoyed his occupational therapy. He turned to her, still smiling and said "Sorry, you bloody kaffir!"

In a blind rage I grabbed his wheelchair and started pushing him out of the department and down the passage to physiotherapy. Then he used what little movement he had of his upper limbs and thrust his right hand into the spokes of the wheelchair. Fortunately his movements were slow and I was able to anticipate what he was about to do and to stop the wheelchair before its spokes amputated his fingers. Then I did what a mother might do who has grabbed her child just before it runs across a busy road: I smacked him across his arm.

When his mother arrived I ashamedly confessed to her what I had done, and why. Her reply was, "My dear I'm surprised you didn't do it long ago!"

Reflections on Postcard #6

³⁰ Occupational therapy assistant (OTA)

³¹ Fictitious name

³² Fictitious name

³³ Kaffir means "unbeliever" and was the word used by colonists to describe the indigenous people of South Africa. It was a word that became loaded with insult, racial scorn and contempt in the days of apartheid, because whites knew how much it distressed black people to be called by this name. Kaffir could thus be likened to an insulting swearword.

³⁴ Nkosizana is the respectful Zulu word for Mistress.

I would now like to explore how the various individuals within this narrative make use of controlling strategies to exert their power over each other. We shall explore this trilogy of responses as follows: Rebecca's response as an African occupational therapy assistant who had been in that particular department for many years and was generally liked and respected by all professional and support staff; Johnny's response as *patient* and young man who had had a very severe head injury at the peak of his adult life, and my response as a fairly newly qualified therapist who had recently become senior therapist and manager of that particular department.

Comment:

- It was still possible in those days for black and white people to have close and meaningful relationships but there were always constraints placed upon such relationships because of apartheid. For example, when Rebecca moved into her own home for the first time, I wanted to visit her in Umlazi³⁵ to see it, but she put me off saying I would possibly be in danger. I wondered at the time whether this was her cop-out because she did not want neighbours to see whites visiting her as this could have put her at risk of being ostracised because of her association with the 'enemy'. Thus it was also insensitive of me not to have thought of this before inviting myself. It could also perhaps have been her embarrassed way of preventing me from seeing her housed in the type of low-cost, shabby little home built in black townships in those days, knowing I was living in a double-story communal mansion on the Berea³⁶.
- Rachel's reaction to Johnny's insult was one of deep hurt and anger and a refusal to have anything further to do with him that afternoon. In her refusal to assist him she was exerting her control over him and, indirectly, also over me, because I was dependent on her to keep Johnny busy while I was working with others referred to occupational therapy.

³⁵ Umlazi is a large township south of the port city of Durban, created in the apartheid days to segregate and distance black people from the centre of the city business districts around which the core of the white residential suburbs were situated.

³⁶ In those days the Berea was an upmarket "white" suburb of Durban overlooking the city and the sea.

- Johnny had very little control over his life. Because of the severity of his disabilities, almost everything had to be done for him. The one way he could exercise some form of control was by what he said. I still don't know the reason he called Rebecca a bloody kaffir, the ultimate racist slur in South Africa. She had apparently done nothing to warrant what is, in any case, an insufferable an insult. She was always very good to him and he appeared to be fond of her. I suspect this was an obtuse and sadly sadistic moment where in an attempt to exert control over her, he had used this racial insult.

This example demonstrates how, even in those whose bodies and minds have been severely compromised by injury, there is the ability to exert power and control over others. This was evidenced not only in his verbal insult, which evoked the expected response, but also in his attempt to jam his fingers into the spokes of his wheelchair, an act that could have resulted in my amputating his fingers through my action of pushing the chair and placed me, as therapist, in the most ghastly position of being responsible for further seriously injuring an already seriously injured individual. Would this not place Johnny in a position of control over me?

- Finally it is necessary to explore my reactions as therapist and, as the manager of that Department, the person ultimately responsible for Rebecca and her actions and those of the people who were receiving therapy in the department. I was thus in a position of substantial power and control.

My initial threat to Johnny, that should he not apologise, I would take away his one real enjoyment, occupational therapy, was a form of discipline and punishment. His refusal to do so, couched in his apology containing the repetition of the insult, showed his contempt at my threat, placing him again in control. My aggressive act of grabbing the wheelchair and pushing him down to the physiotherapy department, puts me in control again! His fingers pushed into the

spokes, puts him in control. My smacking his arm puts me back in control! Or does it? Ethically, morally and professionally, for a therapist to smack a patient, whatever the circumstances, is nowadays reason enough for one to be reported to the Health Professions' Council of South Africa with possibly serious consequences for the therapist.

What this narrative exposes is a series of small power struggles around a racist slur, within a supposedly therapeutic environment. Johnny suffered, even in his small moment of having control, because he missed his occupational therapy and was humiliated by me, his therapist, and surely felt remorse for insulting someone he cared about. Rebecca suffered because of the repeated insult from someone she cared for whom she had provided a lot of support, and I suffered because of my humiliation at my loss of control of the situation. However justifiable some of the reactions in this case might have been, they were wrong and I, as *therapist-in-charge*, failed at the end of the day, because it is rational, controlled thinking together with humility and sensitivity that should epitomise the correct use of power and control in creating a therapeutic and facilitatory milieu for all concerned.

The narrative illustrates quite clearly Foucault's conception of the ways in which power is exercised, and by what means, and the effects the exercise of power may have rather than what it is and where it comes from³⁷. It also demonstrates that power and control in these circumstances operate across all levels and not simply in a hierarchical manner, thus supporting his formulation of power as a multiplicity of forms rooted in the social nexus, and his rejection of power relations in terms of a binary division along class lines or levels of hierarchy/dominance³⁸. In addition, the incident recounted alerts us to the need for occupational therapists, within the therapeutic milieux within which they work, to be constantly aware of the subtle and not-so-subtle interplays of power between therapists and those we serve as well as those we work together with. In this way it is possible to respond in more deliberate, mature and positive ways and so maintain greater harmony in all relationships, on whatever perceived level they may be, or even to

³⁷ Smart, B. Subjects of power, objects of knowledge. In: Smart, B. (2004).

³⁸ Ibid

nurture the development of power when it begins to manifest itself in those who have been dispossessed of it by virtue of their disability.

In its youth and until recently, occupational therapy discourse in South Africa has limited itself by mostly succumbing to the discourses of the medical model and the tacitly acknowledged superiority of the profession's experts in countries such as England, United States, Canada and Australia, often at the expense of the realities of our own unique socio-political discourse. It was and still is, the actions that occur within the language of this discourse that sustain the relations of power and privilege of doctor over therapist, therapist over "patient" and even therapist over therapist. We have to change this if we are to realise our true potential and such change requires that we redefine and reconstruct how we position ourselves within the teams in which we mostly work, how we position ourselves as a unique profession within South Africa with our unique role to play in improving the health and wellness of our people, and how we position ourselves together with those who can benefit from our services.

Power has operated through multiple levels within the development of occupational therapy in South Africa, as was demonstrated in Chapter 4. The profession was born into a cauldron of power plays between government and the 'non-white' people of South Africa, government and the white women of South African, doctors and therapists, therapists and therapists and between therapists and those they served.

Other forms of power

Regulatory bodies

The old South African Medical and Dental Council, in which power was wielded by doctors, psychiatrists and dentists, controlled the registration of therapists; the role and scope of practice of therapists and hence also the curriculum content of occupational therapy training. The current Health Professions Council of South Africa wields similar powers but at least now the Professional Boards and Council are more democratically representative of their stakeholders and the domination of doctors and dentists has been considerably reduced. However, even in this more neutral situation, power plays of a different nature may occur.

Other health professionals

Because of our history, the medical doctor and psychiatrist probably still wield the most power of all team members within the various governmental, non-governmental and private health sectors. There are, however, also members of other health professions who, because of positions of seniority or simply personality traits, wield considerable power within various situations. Occupational therapists are, by virtue of the characteristics sought in their selection, generally peace lovers with gentle natures. They do not like confrontation, and while they are tough and under most circumstances will stand up for principles they believe in, they are also humble and will, in the end, tend rather to capitulate than confront arrogant and/or bossy people. This does not augur very well for their survival in a competitive world³⁹ where there is an abundance of masterful people.

Caregivers and/or families of people with disabilities

This is another source from which power can be exerted. It is not uncommon for caregivers and family members of a loved one who has become seriously disabled to become particularly protective and assertive about what they want for their loved one. This can be quite daunting for therapists and often may create obstacles for achieving medium- and long-term goals with those we serve and those who assist in caring for them. This is why it is so essential that the caregivers and/or family members of those we serve are brought on board from the first instance of contact with the individual with a disability. Enlightening them about the negative effects of their control over those they love and/or care for should help to create a less controlling and more empowering home milieu.

Other Countries

Global perceptions of strength persist and countries that have been training and developing occupational therapists for the longest seem to be those with the greatest power. Thus, countries such as USA, Canada, United Kingdom, Australia and New Zealand are probably those most admired and respected by South African occupational therapists. Unfortunately this creates the impression for many South African occupational therapists, that everything that comes out of these countries is the best, or

³⁹ Joubert, R.W.E. (1997b). **Where from? What now? Where to?** – The 17th Vona du Toit Memorial Lecture. South African Journal of Occupational Therapy, May, Volume 27(1): 5-15.

better than what we can produce. This applies particularly to publications, research and also job seeking. A large proportion of research in these countries relates to Western cultures and contexts and often cannot necessarily be extrapolated to the South African context. Equipment is also often expensive and highly technical and thus unaffordable or inappropriate for many situations in South Africa.

Cultural diversity and occupational therapy

The importance of understanding and respecting the cultural diversity amongst those we serve has already been addressed in this chapter and previous chapters. Manganyi (1972:9) refers to *“the ever important problem of the dynamic relationship between African ontology and health and disease”*⁴⁰. Bonder *et al* (2004)⁴¹ tell us that the founders of the profession in the United States emphasised that therapeutic activities must be prescribed according to the individual's personal and cultural values.

The South African occupational therapy curriculum generally has included a few aspects of the relevant theory regarding the diverse South African cultures and coupled this with teaching a few culturally related activities such as beadwork, grass-mat weaving and one or two others, but the vast majority of our theory and activity repertoire is related to Western cultures and there is little, if any, inclusion of African or Indian cosmology. Few of us understand the significance of the ancestors and sorcery in African culture and their impact upon the health of individuals from these cultures.

Children, for example, are placed under the protection of an ancestor or ancestors by the sacrifice of a goat and, in the past, the skin of the goat was prepared to wrap the baby on the mother's back. Today it is mainly used to make wrist skin bands. This is a form of baptism that puts the baby under the protection of a range of ancestors⁴². Should this child become seriously ill or disabled, it is then perceived as being a punishment from the ancestors for some misdemeanour of a family member. Guilt and shame at this may result in the child being kept isolated and hidden from others.

⁴⁰ Manganyi, N.C (1972). **African ideas of health and disease**. South African Journal of Occupational Therapy. Volume 3 (2): 7-9

⁴¹ Bonder, B. Martin L and Miracle A (2004) **Culture Emergent in Occupation**. American Journal of Occupational Therapy March/April Volume 58 No.2: 159-168.

⁴² Ngubane, H. The ancestors and illness. In: Ngubane, H. (1977).

Various cultures may give different parts of the body value or status. For example, the traditional African man views what may be sexy and erotic to a Western man's eye, for example a woman's breasts, simply as a functional feeder for babies. Hence a mastectomy may have a different kind of significance for the individual undergoing it depending on her culture. To be thin is attractive in the Western Eurocentric cultures whilst plumpness is considered attractive in African cultures. Charlton⁴³ says that in many Asian cultures the body is only one of the many attributes that inform beauty.

Michael Iwama (2004)⁴⁴ maintains that culture is one of the most important issues facing occupational therapy today. In the occupational therapy context, culture has been defined by Krefting and Krefting in McGruder (2003:81) as *"learned, shared experience that provides the individual and the group with effective mechanisms for interacting both with others and with the surrounding environment"*⁴⁵. It is also referred to as *"the values, beliefs, customs and behaviours that are passed on from one generation to the next. Culture affects performance in many ways, including prescribing norms for the use of time and space, influencing beliefs regarding the importance of various tasks, and transmitting attitudes and values regarding work and play"* (Christiansen et al 1997: 61), and it also influences role expectations⁴⁶.

People's culture influences what they do, when they do something and how they do it. It may also influence what may or may not be done, and by whom. Apart from determining which life occupations one performs and how they are performed, culture also influences one's perceptions of health and wellness, ability and disability. Occupational therapists, by virtue of the nature of their work, interact with persons of diverse cultures and thus need to have a sound and sensitive understanding of what culture is and how it is represented in the diversity of people with whom the therapist may come into daily contact. This understanding needs to be exercised is not only towards and in cohesion

⁴³ Charlton, J. Culture(s) and belief systems. In: Charlton, J. (1998).

⁴⁴ Iwama M (2004) **Meaning and Inclusion: Revisiting culture in occupational therapy.** Australian Occupational Therapy Journal. Volume 52:1-2

⁴⁵ McGruder, J. Culture, race, ethnicity, and other forms of human diversity in occupational therapy. In: Crepeau, E. Cohn, E. & Boyt Schell, B. (Editors). (2003).

⁴⁶ Christiansen, C. & Baum, C. Person-environment occupational performance: A conceptual model for practice. In: In: Christiansen, C. & Baum, C. (Editors). (1997).

with those in need of occupational therapy services but also towards other health professionals, employers, caregivers and family members.

It is important not to confuse race and ethnicity with culture. Culture is often used as a polite synonym for race by those who are embarrassed to use the other terms. Race and ethnicity are concepts that are socially constructed and agreed upon in public and private discourse, and can only be understood in the context of their employment at a particular time and place in history. Race is also not a biological entity, because of the variation between and within various races that defies categorisation on a statistical basis. While race and ethnicity are not the same as culture, a culture can be shaped by the historical experiences of oppression or privilege based on membership of a particular racial or ethnic group⁴⁷ as occurred in South Africa.

Culture is intangible, but its effects surround us. In African culture the degree of health and wellness one possesses is closely linked to the degree of harmony or disharmony one experiences in one's interpersonal relationships⁴⁸. Wellness and a sense of joy or being at peace with the world may derive from the performance of various rituals⁴⁹. Disease or accidents that result in disability may be perceived as being caused by supernatural forces, as in the case of Khulu in chapter 7. However outlandish this perception may appear to persons of another culture, it is Khulu's truth and reality and as such should be highly regarded and respected by occupational therapists. Current occupational therapy discourse refers to this as "*culture sensitive practice*" (Awaad, 2003: 358)⁵⁰ or "*cultural competence*" (Odawara, 2005:325)⁵¹.

In order for occupational therapists to gain an understanding of the significant cultural events in the individual's life that may affect his/her occupational performance and consequent health and well-being, it is essential to be able to communicate in a sensitive and appropriate manner with the person concerned. The ability to speak each other's

⁴⁷ McGruder, J. Culture, race, ethnicity, and other forms of human diversity in occupational therapy. In: Crepeau, E. Cohn, E. & Boyt Schell, B. (Editors). (2003).

⁴⁸ Manganyi, N.C (1972). **African ideas of health and disease**. South African Journal of Occupational Therapy. Volume 3 (2): 7-9.

⁴⁹ *ibid*

⁵⁰ Awaad, T. (2003). **Culture, cultural competency and occupational therapy: A review of the literature**. British Journal of Occupational Therapy. Volume 66(8): 356-362.

⁵¹ Odawara Etsuko (2005) **Cultural Competency in Occupational Therapy: Beyond a Cross-Cultural View of Practice**. American Journal of Occupational Therapy. Volume 59 (3): 325-334.

language is therefore prerequisite to the in-depth access of cultural nuances. It is possible to learn about the various cultures theoretically, but it is the getting-to-know the person, understanding the idiosyncratic effects of occupational dysfunction, occupational deprivation or occupational injustice⁵² upon culture and vice versa, that requires careful and sensitive probing if one is to find solutions to these problems.

Culture can, in part, be explained by the ideas, concepts and knowledge of a group of people and includes those aspects such as beliefs, values and norms that shape the rules and standards of behaviour during daily life tasks. Thus, Iwama⁵³ maintains that a study of the concepts that are considered fundamental to occupational therapy should provide a view of the culture that is embedded in the current constructions of occupational therapy. Because the term 'occupation' in occupational therapy refers to the main domain and therapeutic medium used in this profession, it refers to everything people do throughout their day and lives that occupies them and includes groups of activities and tasks that are named, organised, and given value and meaning by individuals and a culture⁵⁴.

Iwama argues that occupation, from a Western world perspective, is imbued with more profound meanings which contribute towards how one defines oneself as a person, because Western society places emphasis upon the individual as being a rational, reflective, independent entity. Thus the construct of occupation for many Westerners becomes integral to their being and identity as individuals. It is in the doing of occupation that one becomes oneself, one expresses one's identity. And it is in this way that one attains a sense of health and well-being⁵⁵.

Christiansen(1999:547)⁵⁶ asserts that occupation is the key "*not just to being a person, but to being a particular person, and thus creating and maintaining an identity*". Occupations provide a sense of purpose to our daily lives and over time give meaning to

⁵² See Chapter 5 footnote 3 page 90, which explains these terms.

⁵³ Iwama, M. Situated meaning, an issue of culture, inclusion and occupational therapy. In: Kronenberg, F. Algado, S. and Pollard, N. (Editors) (2005a).

⁵⁴ Canadian Association of Occupational Therapists. **Enabling occupation: An occupational therapy perspective.** (1997). CAOT Publications ACE; Ottawa On.

⁵⁵ Iwama M, (2005a)

⁵⁶ Christiansen C (1999) **Defining lives: Occupation as identity: An essay on competence, coherence and the creation of meaning.** American Journal of Occupational Therapy Volume 53(6): 547-558.

our lives, which in turn contributes to our wellness. He makes a distinction between wellness and health and maintains that the ultimate goal of occupational therapy is well-being⁵⁷. Occupational therapy's constructs of agency, praxis and reflexivity are supported in modern social theory and the ideology that occupation is more than doing but also forms part of the 'being' and 'becoming' of the individual and has been reified in modern Western thinking. Because of this, Iwama (2005a:130) maintains Westerners find it difficult to imagine that occupation may hold '*particular culture-bound meanings shaped and influenced by prevailing social and cultural contexts*'⁵⁸.

Iwama⁵⁹ demonstrates the congruence between occupational therapy theory and Western worldviews by examining two common conceptual models of occupational therapy i.e. the Model of Human Occupation (MOHO) and the Canadian Model of Occupational Performance (CMOP).

Using a systems arrangement, MOHO's structure and concepts and the metaphoric representation of human agency demonstrated in this model, reflects almost every descriptor of modal Western tendencies and cosmologies such as 'self efficacy', 'personal causation' and 'volition'. The 'self' is a solitary figure central to the 'system', and interacts with an environment that is in opposition to it. Successful human agency is conceptualised as a state of efficiency in which one can exercise one's determination to act on the environment and control one's circumstances⁶⁰. Compartmentalising these concepts, Iwama maintains, emanates from the Western notion of the individual as analytic, materialistic and rationalistic.

Similarly, the CMOP demonstrates the importance of mastery over environment and the primacy of the individual as an agent of change within the environment. This mastery of environment and of self is thus equated with a healthy state of being. In this way, occupational therapy theoretical models reify the Western ideals of health, which are defined along independent, individualistic and rationalistic lines. Iwama thus asks the

⁵⁷ Ibid

⁵⁸ Iwama (2005a)

⁵⁹ Ibid

⁶⁰ Ibid

very salient question, “*how appropriate, then, are these depictions of health for societies that abide by very different social and cultural constructions of reality?*” 13⁶¹.

Awaad⁶² maintains that where culture has been incorporated into theory through models such as MOHO, these models are criticised for not adequately addressing cultural issues, recognising stereotyping and taking into account the practical aspects of assessing the cultural backgrounds of those using the services of occupational therapists.

Mocellin⁶³ takes the criticism of models further when, using the Model of Human Occupation as an example, he maintains this model’s conceptualisation of humans as open systems results in a conflict between the humanistic values of the profession and the necessity to demonstrate the efficacy of its interventions. As such, it negates those individuals who, for reasons such as cultural differences, are either incapable of either maintaining interactions with the environment and/or of undergoing some internal positive changes, or unwilling to do so.

Kondo⁶⁴ criticises the Western medical model influence upon the Japanese occupational therapy curriculum. As simple but very relevant examples, he cites the conflict amongst Japanese therapists trained in the Western medical model ideology, in which they are expected to aim at making a disabled person independent when their own ideology is one of encouraging interdependence, an ethos that is akin to the African concept of *ubuntu*⁶⁵. As an example of such conflict Kondo cites the Western emphasis on the importance of training someone to use a wheelchair in a cultural environment which does not support this concept; Japanese homes are very small and compact and not designed for wheelchair use; furthermore, bringing a ‘vehicle’ with wheels into a home is tantamount to sacrilege if one considers the importance Japanese cultures place on removing one’s shoes before entry into a home.

⁶¹ Ibid

⁶² Awaad, T. (2003). **Culture, cultural competency and occupational therapy: A review of the literature.** British Journal of Occupational Therapy. Volume 66(8): 356-362.

⁶³ Mocellin, G.(1996). **Occupational therapy: A critical overview: Part 2.** British Journal of Occupational Therapy. Volume 59 (1): 11-16.

⁶⁴ Kondo, Tomoko. (2004). **Cultural tensions in occupational therapy practice: Considerations from a Japanese vantage point.** American Journal of Occupational Therapy. Volume 58(2): 174-184.

⁶⁵ “I am what I am because of others.”

The argument innate in Iwama's question about the appropriateness of these depictions of health for societies abiding by different social and cultural constructions of reality, is particularly relevant in the South African context in which we have a convergence of Western, Eastern and African cosmologies.

Ngubane⁶⁶ maintains that there are certain notions of health, diseases and causation of diseases that are based on Zulu cosmology and philosophy that are referred to as *ukufa kwabantu* (disease of the African peoples) where the symptoms are perceived as being associated with African peoples only, and their interpretation and the attribution of causes are bound up with African ways of perceiving health and disease that non-Africans do not understand.

Unlike the Western views of transcendence of self over environment, the Zulu view, for example, is that there is a special relationship between person and environment, and that the various plants and animals within the environment affect and influence that environment which in turn affects the unique atmospheric conditions of a particular environment. Thus, moving from one environment to another may cause one to become ill if one is not adjusted to that environment. Also, when moving away from a place, the people and animals leave something of themselves behind and absorb something of the atmosphere through which they move. These various 'atmospheres' can affect the health of those who carry them or come into contact with them⁶⁷.

The Zulu have a word, "*lungisa*", which basically means to put in order, adjust or set as it should be or, as Ngubane puts it, to bring 'balance' and order to a situation or person. This notion extends to restoration of moral order, meaning, in a symmetrical sense, putting right the position of people *vis-à-vis* others i.e. creating symmetry in relationships. It is this need to restore balance that Ngubane maintains is the pivotal ideology around which practically all the notions that constitute 'African disease' or *Ukufa Kwabantu* revolve. The Zulu people perceive good health as consisting in more than simply a healthy body; it depends instead on everything that concerns him/her within

⁶⁶ Ngubane, H. Natural causes of illness. In: Ngubane, H. (1977)

⁶⁷ Ibid

his/her universe should be in harmony and concordance⁶⁸. Thus, factors such as poverty, drought, hungry cattle or a quarrel with one's neighbour, for example, will mar one's health and wellbeing.

There is no gap in the African worldview between the self and the phenomenal world. It is more a 'man to person' than a 'man to object' concept of reality in which the self embraces a communal rather than individual orientation. This ontology is commonly referred to as *ubuntu* and serves as a moral-political philosophy that entrenches a sense of collectivism through the assumption of being linked in a web of inter-relatedness with others⁶⁹.

Western individualism and the ideology of individual autonomy and transcendence of man over others and nature are in direct conflict with the unifying vision of the African idea of *ubuntu*, which is enshrined in the Zulu maxim '*umuntu ngumuntu ngabantu*' i.e. a person is a person through other persons. It articulates an essential basic respect and compassion for others⁷⁰, and lies at the heart of a collective consciousness of African people as manifest in their behaviour patterns, expressions, and spiritual self-fulfilment, in which the universal brotherhood (sisterhood) of Africans is concretised through sharing and treating others as humans⁷¹.

To understand African ontology it is first necessary to understand the differences between this system of thought and the European philosophies. Manganyi maintains that African philosophy, from the Sudanese to the Southern *Bantu*, presents a view of the world that is diametrically opposed to the traditional philosophy of Europe⁷². The cultures of Asian peoples, who comprise nearly 50% of the world's population and a substantial proportion of the South African nation, also perceive the world differently from their

⁶⁸ Ibid

⁶⁹ Duncan, M. (1999). **Our bit of the calabash: Thoughts on transforming occupational therapy in South Africa**, 18th Vona du Toit Memorial Lecture. South African Journal of Occupational Therapy. Volume 29(2): 3-9.

⁷⁰ Louw, D. (circa 1997) **Ubuntu: An African Assessment of the Religious Other**. An updated version of a paper presented at the Annual Meeting of the American Academy of Religion, San Francisco, 1997. <http://www.du.edu/wcp/Papers/Afri/Afrilouw.htm>.

⁷¹ Prinsloo, E. Ubuntu culture and participation management. In: Coetzee, P. & Roux, A. (Editors) (1998).

⁷² Manganyi, N.C (1972). **African ideas of health and disease**. South African Journal of Occupational Therapy. Volume 3 (2): 7-9.

Manganyi (1972) African Ideas of Health and Disease: 7-9

Western counterparts. Iwama⁷³ maintains that Asia's varied cultures, which have evolved their own distinct philosophies, epistemologies, value patterns and moral and ethical systems represent a significant testing ground for occupational therapy's so-called universality. Because of its origins within Western cultures, occupational therapy has rather arrogantly assumed that the "doing, being and becoming"⁷⁴ relationship that applies to people of Western cultures and the occupations they are involved in daily, is a universal concept.

This, in my opinion, is one of the biggest flaws in our epistemology. We preach the gospel of inclusiveness, holism and treating each individual as a totality but there is very little research or evidence to demonstrate that we have really interrogated how the various ontologies and epistemologies of cultures, other than Western cultures, construct their ideological worldviews and their concepts of occupation and its relationship to health and wellness. How then is it possible to be inclusive and holistic with all we may serve if their different cultures and cosmologies are barely comprehended?

Unlike Western cosmology that perceives the world as God, humanity and nature hierarchically configures and rationally separated from one another. Eastern cosmological perspectives, similarly to African ones, place self, nature and society as a closely knit and integrated whole. *"The Eastern world view... may limit the conceptualisation of the centrality of 'self' in the universe as well as deflecting reliance on the attribution of accomplishment away from a solitary, centrally situated me. And instead of offering a monotheistic view of an ultimate singular truth, Eastern cosmological view places deities together with humans and nature in a tightly bound singular entity, creating a polytheism in which multiple truths can exist at the same time"* (2005a: 135)⁷⁵.

In African cultures and many Eastern cultures, it is the belonging rather than the doing that constitutes the *raison d'être* and shapes the social ethos. Personal identity and

⁷³ Iwama, M (2004): Meaning and Inclusion: Revisiting Culture in Occupational Therapy, 134-136.

⁷⁴ Wilcock, A. (1999). **Reflections on doing, being and becoming.** Australian Occupational Therapy Journal. Volume 46: 1-11.

⁷⁵ Iwama, M. Situated meaning, an issue of culture, inclusion and occupational therapy. In: Kronenberg, F. Algado, S. and Pollard, N. (Editors) (2005a).

meaning reside in the social collective, rather than in personal agency. Consequently the prominence given to independence and autonomy in Western concepts of rehabilitation may be inappropriate or irrelevant in cultures where interdependence and dependence are paramount as social values ⁷⁶.

South Africa is a country with a diversity of Western, African and Eastern cultures. I do believe that, since gaining democratic independence in 1994, South Africans have commenced on a path of developing a unique, variegated South African culture, but within this hybrid remain the distinctive needs and nuances of each individual culture. It is imperative that the South African occupational therapy curriculum seriously acknowledges this fact and commences the planning and implementation of a curriculum and research programme that appropriately investigates and documents the particular perceptions and dynamics of human occupation and its role in the health and wellness of individuals within each distinct cultural group.

Having explored the historical routes and roots that occupational therapy's development in South Africa has taken over the past fifty odd years, it is now necessary to summarise the effects of this upon our epistemology and look at what has been beneficial and what has been detrimental about this past.

⁷⁶ Ibid

PART 3

Destinations: Using the Roots to Find New Routes

- 👤 Sam's story: Those we serve – serving them right.
- 👤 So what? How does all this affect the profession of occupational therapy in South Africa?
- 👤 Reconstructing an occupational therapy identity.
- 👤 Changing the routes/roots and picking the fruits.

CHAPTER NINE

Sam's Story: Those we Serve, Serving them Right

Route map: Using as an example the second narrative life story of a disabled person, this chapter will try to uncover some of the deep anguish, anger, yearnings and frustration that people with disabilities experience, particularly those located within a rural, African and socio-economically disadvantaged situation. It will reveal how wrong decisions in the rehabilitation process can seriously affect the future of those we serve. As such it will lay the foundation for discussion about the characteristics, skills and abilities that the 'therapist' should possess in order to avoid such wrong decisions and provide an appropriately sensitive and enabling service to those in need of it.

I would like to share Sam's story with you because I think it epitomises the plight of people with disabilities in South African and how the 'system' has failed them and is still failing them. However, it simultaneously reveals, as did Khulu's story in Chapter 7, a wonderful resilience and *joie de vivre* that many people with disabilities have and that has so much potential for development and growth, but is instead suffocated by the health system and many people without disabilities within this system. It is stories such as these that illustrate the real challenges that those of us who work with people with disabilities should be addressing.

Letter #3: Sam's story¹ - the context

Sam is a young Zulu man of 21. He has athetoid cerebral palsy, the result of a birth injury. This form of cerebral palsy is probably the most disabling of all types because it results in constant fluctuations in muscle tone. The effects of this upon Sam's function are enormous as he has very little control over his muscles and thus when attempting to initiate any movement, instead of having smooth, finely coordinated movement, he has writhing, shaky and totally uncoordinated movements. This abnormal tone has also affected the muscles for articulating speech, making it extremely difficult to understand what he is saying. It has not, however, affected his intellect in any way.

Sam and I have been friends for approximately 3 years now and I can best describe him as a bright, intelligent, handsome young man with a gentle, sensitive and caring nature and an excellent sense of humour. His intelligence and personality are thus trapped within a body that literally will not cooperate and can do very little for him. As a result Sam is wheelchair bound and requires assistance from others for almost all his daily life activities. To add to this more than frustrating situation, the possibility of compensating for his physical functional loss by being able to reveal his intelligent, bright and loveable personality, through verbal communication, is severely limited by the fact that he has such difficulty speaking and making himself understood by those who are not patient and concerned enough to take the time to get used to his particular way of communicating.

¹ Fictitious name are used throughout this discussion on Sam to protect his identity

Sam was sent to special schools where, as will be revealed in extracts from his essay, he encountered some people whose support and attitudes contributed to his progress and life enhancement but where he also encountered others with attitudes and an approach that has contributed to placing barriers in the way of the attainment of his full potential. Let me explain this more clearly: Sam's greatest assets, given his substantial physical disability, are his intellect and personality, thus his schooling should have focussed on developing his cognitive and personality skills optimally which would have made it possible for him to become skilled in a vocational area where cognitive ability and personality are more important than physical ability. He has enough control of his right hand and arm to work a mouse and has subsequently learnt to use a computer. (He can also SMS on a cell phone). Instead he was placed in a pre-vocational class, which is a polite term for special class created mostly to accommodate children with severe cognitive impairment. The emphasis in a class such as this is on development of practical (physical) skills rather than cognitive skills!

It thus defies logic that those who were specifically trained to 'understand' problems such as Sam's, in this situation could have placed such a severely physically disabled child into a class where physical ability was probably the most important requirement.

Sam did, however do computer courses at school, and after school, and is now competent, albeit slow, in using a computer. Had he been encouraged to follow an educational stream in which adequate support and focus on cognitive development had been provided he would, I believe, have been able to pursue a vocational course such as data capturing, computer programming or writing/journalism. As a result he could have quite possibly have been employed in the open labour market, and have earned a high enough salary to employ an assistant. This would have provided him with greater quality of life through interaction with others and having the scope to express and exercise his abilities through occupation, which would also have contributed, to creating the greater possibility of entering into a loving relationship with a life partner.

Currently he is frustrated, lonely and isolated, spending his days at his semi-rural home, using his minimal disability grant to pay for an assistant to assist him during the day while the rest of his family are out working or at school. He mostly occupies himself with writing his life story on a donated computer, watching television and sending sms's to friends. Over the weekend he sometimes goes visiting with his family or friends and family come to visit him. But his autobiographical essay reveals a deep and desperate need for contact and relationships with other young people of his age and to engage in the types of activities that occupy his peers. To be employed in a job, living a normal life and achieving his dreams.

Method and analysis

As part of the data gathering for this research, Sam was requested to write an essay about himself, in which he covered the following areas:

- ? Who I am.
- ? What being disabled means to me as a South African.
- ? My experience of rehabilitation and occupational therapy.
- ? Other things that I think are important to mention.

I am going to take you through Sam's response to these questions as part of my analysis of his essays and will be using the results of this analysis as reinforcement of my argument in the chapters that follow. But at this stage I must state that what stands out to me about Sam, revealed through my acquaintance with him and the content of his essay, is his depth and the level of insight he has into the needs of people with impairments and disabilities², as well as his ability to problem solve around these needs and produce very plausible solutions.

Whatever Sam has achieved today I suspect has been largely due to his own perseverance and strong personality, the love and support of his family and belief in his potential on the part of a few of those professional people (including teachers, speech therapists, physiotherapists and occupational therapists) who worked with him. But the tragedy is that it was those without the insight or belief in his potential who had the final say (power?) in terms of deciding his future at a very vulnerable stage of his personal, physical and occupational development.

In addition to this, I believe that almost the entire team of professionals who worked with him, inadequately assessed his potential. One can pose the question whether this was as a result of the prevailing attitude to severely disabled children at the time, or simply one of those unfortunate and totally unnecessary mistakes arising from a training that reinforced the generally negative attitude in which the focus was on weaknesses rather than strengths. Or was it both? Regardless, there are far too many Sam's that slip through the net of rehabilitation and through the fingers of rehabilitation professionals, never to be given the opportunity to reach their true potential.

What I have tried to do in this analysis is to provide a narrative portrait of Sam, the attractive, amusing young man with a very severe physical and communication impairment and show this impacts upon his life. Too much in-depth microanalysis would, in my view, destroy the richness of his voice and the messages he so powerfully

² It is important to distinguish between disabilities and impairments: an impairment is the natural consequence of the illness or trauma upon function. For example, in Sam's case the fluctuating muscle tone in his lower limbs makes it impossible to walk. Disability refers to the way in which the attitudes of people without impairments towards those with impairments, disable people with impairments, (i.e. through attitude and failure to provide adequate support systems and infrastructure to ensure for optimal quality of life).

communicates. I have thus tried to avoid word-for-word analysis but rather joined together aspects of the text to disclose his voice. Sam is particularly articulate in English although his mother tongue is isiZulu. His written English reveals some minor spelling and grammatical errors as well as occasional lapses into the phonetic type of spelling that I have discussed in Chapter 2 page 58. I have quoted him verbatim to retain his character. In order to reveal more effectively and evocatively the inner Sam, I have cut and pasted and moved about relevant sections from his various answers to my questions and tried to weave them into a collage of a coherent set of thoughts and views. I allowed Sam to read the completed chapter and he was satisfied with the results and did not request any changes or deletions.

His experiences, insights, views and perceptions as a particularly sensitive and resilient young man reveal the isolation, marginalisation and loneliness that his disability has brought upon him, how important his relationships with others are and how his dreams and needs are like those of any other young man of his age, but made so much more difficult, if not impossible to achieve, mostly because of the attitudes of people without disabilities and because of the lack of adequate societal infrastructure to accommodate his special needs.

Sam told me that he could not recall much of the occupational therapy he received at school and it appears that at that stage of his life, all the professional people he dealt with at school were perceived by him as teachers; no distinction was made between teachers and therapists, thus when he uses the term 'teacher' it could refer to either of these professional groups.

In the final analysis offered below I have categorised the main themes that have emerged from Sam's life story as *revelations*.

? SAM – who I am

Comment: The first revelation about Sam that emerged through reading his life story was how he particularly values his interpersonal relationships with others. Throughout the essay he refers to his relationships with others and considers himself particularly blessed because he has such a wonderful family, both his family of origin and also his extended family, who appear to provide a strong source of support and enjoyment for him.

I have a really big family and it feels really wonderful to know that I can ask any one of them for help and if they can they won't think twice (about helping him).

I thank God for give me the family that I have I just wish that other disable people could have a family like my. A family that is not ashamed about having a mamba (member) of the family a disable person.

I like going out to see my relative and sometimes they call me to come to visit.'

I also have friends who are always willing to help me whenever I need help, I have really wonderful friends. [But as the essay progresses, a sense of urgency emerges about how important relationships are and how, because of his isolated circumstances, these interactions are not as frequent or satisfying as he would like them to be.]

I like meeting new people or new friends, whenever I go somewhere I've never been I try to make new friends and keep in touch with them [Sam uses sms and air time to do this and this forms a very important link with the outside world for him also because he can be easily understood through it. However it costs money of which he does not have enough, so this pastime or occupation, which is crucially important to him, has to be seriously restricted.]

Am (and) sometimes when I'm with other people that I don't know very well I don't talk that much because I know that it is not easy to understand me. But when I'm with my family or friends I talk too mush (much) that is one of the reason that alto (a lot) of time I use sms. It Chipper (cheaper) and it easier to understand me.

[It is clear that his school days were very important to him because of the contact with other children and people and the chance to engage in some of the things that young boys of his age should do.]

When I was at school I had friends and I really like to hang out with them it was great. We would joke around talk about soccer, am (and) cars we never talk about girls, or maybe I never talk about girls. You see I was the good boy out of all the guys, if you know me I wonder if you'll believe me. [Here Sam's mischievous sense of humour

reveals itself, like all boys of his age he's mad about girls as will be revealed later.] There were five of us me, Jabu, Themba, Sanele and Sipho and then there were other kits (kids).

[The emergence of loneliness and isolation is captured in the next statement.]

When I came back from school for the weekend they would call me, but now it like once in a while. I have new friends we content (contact) each other a allot of time we chat with one another by SMSing forward and back it really cool.

[Some of these friends are students from UKZN he has met through attending the Community Based Support Group close to his home once a week, others he has met at Interface³ conferences. Others are older concerned, professional people (OTs, teachers, physios and speech therapists) who have become friends through working with him and realising his potential. But the contact is rarely face-to-face; it is mostly in the form of the diluted words on the minute screen of a cell phone and sometimes through a phone call from one or other of these people.]

But sometimes it great to hear a friendly voice. My friends are Ronni, Rene, Sharon, Mary⁴ [Those older [concerned, professional women I spoke of earlier] am (and) I'm shore that they are many more [Are there?]. Many of my friends are friends that help me and believe in me just like my family You see I don't go out as mush (much) as I would like to so it not easy to have friends.

[Perhaps one of the most poignant references to his relationships is that regarding girlfriends:]

I am a young disable person and as you'll (you all) know, young people have someone special in their life. Well I'm looking for someone and I muse (must) say it is not easy I mean just to tell someone (presumably that you like or love them) it is not easy because you don't know what would they say. Well ashley I do (know what) they will say, "We can be friends" and they (then) sometimes they don't even mean it. ...Do I blame her? [Here the plural pronoun 'they' becomes the gendered singular 'her'.] No I don't but it doesn't mean that I'm not hurting it does hurt. Whenever a girl says we can be friends I cent (can't) help it but to wonder if it because I am disable.

Comment: The next revelation in Sam's story is his own attitude towards his impairments and disability. Sam has internalised his disability; he perceives it as being

³ Interface is a national organisation that promotes alternative and augmentative communication for people with severe communication problems. Sam has been invited to several of their meetings and conferences where he meets young people with similar problems.

⁴ All fictitious names.

a divine challenge or God's having a plan for his life, it is part of what and who he is, thus he does not want to change it. All he wants is for the world to change to accept him as he is and for the world and people/friends and jobs out there to become more understanding and accessible

I believe in God, I believe that my disability it wasn't a mistake, I believe that God has his reason and a plan for me...When I pray I don't ask God to make me not disable but I pray to have a life. I know who I am and where I am going I just pray that my dreams are what God has plan for me... [Sam shows the typical yearning of any young man of his age to be needed and wanted as well as expressing the importance of having a positive self-image. His frustration at not being able to physically do things echoes through some of the lines.] I think it is important to know what people think about you but you must be able to handle it. Now as a young person I will like to do what other young people do. Well not everything that they do but I will like to be able to go out to see a movie or go to a party. Am (and) have a job, am keep busy you know to be able to say I have things to do people to meet. I really like that saying [see preceding underlined] it makes anyone feel important. To hear someone saying that they (there) is something that they are working on and will like my input. To share ideas... to combine ideas with other people and see what comes up.

[When talking about this special girl that he likes he says:] The think (thing) that I like about this girl is that I can be myself when I 'm with her or when I was with her. You know I don't have to forget (about) or live (leave) out my disability.This girl she's very special to me but every girl needs to be shown that she's special. [Here again the frustrations of his physical impairments are evident] but I count (can't) the only think (thing) that I can do is tell her, is it enough? I don't know. But hey that is life and one can only hope. But right now I'm so terrify (terrified) that I won't ever see her again. That is one of the bedside (bad sides) of disability, I count (can't) go where I want to go. OK enough about that. [Sam's resilience in lifting himself out of thoughts that potentially take him into self-pity or depression can be observed here; he also frequently uses rhetorical questions that he either answers himself in his essay or leaves unanswered.]

? Revelations about being disabled in South Africa

In answering the questions about **“what disability means to me as a South African”** and **his experiences of rehabilitation**, Sam brings us closer to his own experiences and thoughts around disability issues in this country, particularly in his context where poverty is rife. It is semi-rural, thus access to transport and city life is not easy for a young, wheelchair bound, disabled person and in an area where traditional Zulu cultural influences and attitudes about disability prevail. Of particular note are his feelings about

those professionals (teacher and therapists in his special school) with whom he came into contact.

South Africa hasn't really taken **(taken)** time to think about disable people or they (South Africans) have just started... [The collective blame implied in the term 'South Africa' and the words 'hasn't really taken time to think about' reveal the immensity of isolation and marginalisation that Sam feels. The underlined statement in the last part of this sentence is reassuring and provides hope that disabled people are starting to feel that the very progressive policies and relevant aspects of our human rights charter are beginning to bear fruits but still have a long way to go. He is particularly concerned at the ignorance and attitudes of non-disabled people and professionals in their dealings with people who with impairments and how this mindset stigmatises, disempowers, disables and marginalises them, stifling and suffocating their dreams and aspirations.]

.....the parents that has children that are disable some of them have no idea how to handle it. So they hide them behind close doors (1) and for me it is just like killing a life. (2) Because (3) what (is) the use of living (4) with out dreams (5), hope and wanting to be success full as you can be in life?

[Here (1) Sam is possibly alluding to a tendency in his community for children with disabilities to be kept hidden because their presence is perceived by some as a manifestation of the forefathers' anger at some omission or commission that has displeased them. He is so disturbed at this prospect that he implies it would be better to be dead (2), but this idea of being killed by the acts of others is juxtaposed onto the next sentence by the word *because* (3). He then questions the purpose of living if one cannot realise one's dreams and aspirations (5). This sense that it is better to be dead than being hidden and isolated from society is transposed into the next sentence where he indicates that he would rather be dead (4) than not have dreams, hopes and aspirations.]

? Revelations about Sam's perceptions of health professionals and educators in special schools

[**Note:** I have provided a more in-depth analysis on this response because it is so significant to this research].

But some of us when we come out of school and we get told (6) that what we've been doing at school it was a west **(waste)** of time. (7) I think that some of the people (8) that work in **(special)** schools they don't really believe in us (9). They think that when we live **(leave)** school we should go home and be a part of the furniture (10). But if they do not believe (11a) that a disable person can make something with they **(their)** lives (11b) they should not work with us (12). **(And later in discussing his experiences of rehabilitation he says)....** when I first went to school they wanted to kick me out (13a) just because they thought I was too disable (13b). They just looked at my

disability not at my brain (14) Luckily my first teacher saw (15a) that I had a good working mind (15b) and she Ashley cried (16a) so they (16b) wouldn't kick me out. (17a) I mean if we get kicked out of the schools that we suppose to get help from where do they expect us to go... (17b). I mean think about this, I was at the same class for about three or four years and didn't get anything that will be useful in my life (18). But instead this class (19a) (**special class**) keeps blocking me (19b) when I'm trying to get on with my life.

[This is perhaps one of the most disturbing of Sam's revelations. In (6) he is referring to an OT friend who was trying to get him government funding to further his computer training (SETA⁵) and who revealed to him it was not possible because he did not have adequate educational qualifications (7). In (8) and (9) he reveals his concern about how some of those who work with children with disabilities do not have the correct attitude to do so (10). The sense of feeling marginalised and objectified comes through in his statement about being perceived as part of the furniture (12). The repetition of "they" and the "people" (health professionals and educators) (8, 9, 10, 12, 15, 16b) and their perceived lack of faith in the abilities of the people they work with (9, 11a and 11b) and lack of insight into his real abilities (13b & 14, 14b) emphasises his deep sense of desperation and indignation at being objectified (12) and not being taken seriously by the very people who were supposed to be custodians of his future... His indignation is revealed again in (13a) and (17a) in the use of the derogatory words *kicked out* to convey how they wanted to evict him from the very institutions that were designed to help him (17b) ironically because he was too disabled (13b). He dissociates his physical disabilities from his cognitive abilities (14). It is also interesting how he reveals the *medical model* orientation of those health professionals and educators supposedly caring for him, in their preoccupation with his impairments and lack of attention to his abilities (13b and 14).

Fortunately, some of his therapists and educators believed in his potential (15a, 15b 16a). (His use of the word teacher could be any one of the remedial teachers or therapists who were helping him at the time; he revealed to me that in those days he could not distinguish between therapist and teacher so he referred to them all as teacher.) This particular person reveals what Sam considers the right characteristics of such a professional i.e. being able to discern the strengths of those they work with (15b) and showing compassion (16a). The disdain he feels at the treatment he received at a school (11a, 12, 13a, 13b, 14) which was supposed specifically to be geared to meet the needs of children with disabilities (17b) is transposed onto his "class" which (19a) becomes a metaphor for those human obstacles (19b) that blocked his progress.]

⁵ SETA: Services Sector Education and Training Authority: are committed to the facilitation and promotion of development and delivery of education and training initiatives and the achievement of competencies leading to qualifications through learnership and skills programmes. The S.A Government has allocated substantial funding for those who qualify to access for their own training but they must have basic qualifications to do so. Sam's qualifications are not adequate to access this funding.

? Revelations about people who work with disabled people

Sam makes a very disturbing and contentious statement about those individuals with incorrect attitudes and abilities who work with disabled people and this refers to both health and education professions as well as the (wo) man in the street: (1) *I think if you don't have a heart to work with disable people then please do not work with disable people!!! I feel very strongly about this "if your heart is (not) into helping me then please don't. At the end of the day you will make my life worse. [It could be that he is referring here to not wanting to be helped too much by able-bodied professionals, but I suspect his statement in the preceding sentence (1) "if you don't have a heart", is meant to be echoed in the following sentence but that he accidentally left out the 'not'.] So what is his answer to replacing these "heartless" people? We need people that when they look at us they see success, real dreams and they want to help. They don't forget you and when they found an opportunity to help you they do. [This seems to be referring to the people who made promises to him and never met them or seemingly forgot about him. Sam is not a person who likes handouts, but he is realistic about the fact that because his disability is so severe, and because his parents are financially disadvantaged (they run a roadside fruit and food vending stall), he requires particular support to kick start him] When I left the school that I did the course at (a computer course which he did after leaving his special class) the people that I worked with they actually made promises to me. I didn't have my own computer so they ashley promises me to get me my own computer but it never happened...What happened? I don't know but hey that is life right? (2)...If you are (3) going to work with disable people please I'm begging you (4) to have a heart or please don't work with us. It hard enough to handle our disability we count (can't) handle your attitude (5) as well.*

[Sam's resilience is revealed again in (2) where, in spite of all the setbacks and disadvantages in his life, he rather casually tosses it off with – "but hey that's life". His directive to health professionals and educators to get their attitudes right is subjectified and directed straight at us in his repetition of the words *you* and *your* (3, 4, & 5) in this statement.]

? Revelations about the material costs of being disabled and attitudinal and physical obstacles

[Sam's story also reveals the expense of being disabled and how inadequate his disability grant is, particularly because he also has to use part of it to employ an assistant to help him during the day. Some of the constant attitudinal and physical obstacles faced throughout his life are also revealed]...*I stay with my cousin and I pay her with my monthly disability grant⁶In South Africa alto (a lot) of people don't have jobs and the things that disable people need are expensive. So what happens is that the disability grant get used for the family needs (1) and not for the needs of the person*

⁶ The monthly grant for people with disabilities is currently approximately R780, the equivalent of approximately £78 or \$120.

who is disable. So you'll see a disable person with no shoes maybe with old pains (pants) on. You know it just wouldn't look like they are getting a disability grant.

[What Sam is alluding to here (1) is a common practice amongst the very poor in his area, where there is little or no income, and consequently they use a disabled family member's grant is often used to support the entire family. In a strangely paradoxical way, this may have a beneficial effect for the disabled family member because they may rise in status within the family and also have a sense of importance in feeling themselves to be the breadwinner of the family. However, it also has very serious negative consequences in that the disabled family member is open to exploitation and is often left with no money for necessities such as medication and assistive devices.]

...but some of us we are lucky to have families that knows that we are also ☹ people (♫) [note again his allusion to the fact that disabled people are objectified♫] and we also ☹ have need♫. Things like close (clothes?) CD's, tapes, airtime (for cell phone) you know things that young people need and like...I have heard many disable people complaining that the public transport they don't take them....If I get a job how would I get to it? How much will it course (cost) me to get to work every day? I mean I count (can't) just work for transport I also ☹ have (other) needs. (♥♫)...Another thing that I have a problem with are the shops, some of the shops I can't get to them because they are not wheelchair friendly [inaccessible]⁷. ...The schools for disable people, it great that we can also ☹ go to school [note the implication here that he considers it more a privilege than a right] and it good to know other disable people. It even more great if you can make friends☺ and it bit (beats) staying at home for the hall (whole) day. ☼

[(♥) Here Sam is alluding to the fact that it is so expensive for disabled people to use public transport i.e. they have to pay two fares using a minibus-taxi⁸, one for themselves and one for the wheelchair, that a large proportion of his income would have to be spent on transport. These 'other needs' (♥♫) could be alluding to those personal relationship needs. The repetition of the word 'also' ☹, when referring to people with disabilities in relation to others without disabilities, shows his sense of marginalisation as a disabled person. The need to be with friends ☺ and the loneliness of staying at home all day ☼ echoes many of his previous sentiments about the need to integrate and belong within his society, like most young people of his age.]

⁷ Legislation in cities and towns in South Africa makes it mandatory that public buildings are made accessible for people with disabilities; unfortunately this does not occur in the rural areas similar to where Sam lives and where most shops and stores are not accessible.

⁸ A large proportion of South Africans use the minibus taxi as a mode of transport, this is usually a 12- to 15-seater vehicle such as Volkswagen combi or Hi-ace van.

? Revelations on the role of disabled people in South African society

We need people who are disable to go out and say that you can have a life with your disability (1)... But also we as disable people we also need to take the responsibility of saying what we need (2). If I see someone that is disable and I know he or she can be help, I have the responsibility to tell them (3). [And he comes up with some pretty broad minded and progressive ideas considering he is unaware of the latest policy on inclusive education.]. ...Alto (a lot) of people don't know that mush about disability (4) and we expect them to trite (treat) us normal (5). Well to them we are not normal to them they (there) is something wrong with us and I don't blame them (6). I mean think about it disable kits (kids) are at school (special schools for children with disabilities are his frame of reference) or at home (7) (segregated, isolated and marginalised) so how can other people know about disability. We are hidden from other people (8) but at the end of the day we want (to) have a normal life with people. We should start being with other people (9) from when we are young it wouldn't be so hard for people to trite (treat) us normal (10). They are a alto (a lot) of things that can be done to get disable kits with other kits (11). Things like having schools that mix disable kits with other kits. I think it will work beautifully. Am (and) organizing parties (12), going out together (13), mix kits together as mush as possible (14). Don't live (leave) it anthill (until) kits have groan (grown) up (15) then try to (m)ix them with other people do it now...People have to see, to know how it really is to be disable before they can accept us (16). It is up to us to say hey we are here we are also people with dreams and something to offer.

[The importance of rehabilitation professionals empowering people with disabilities with the ability to be assertive about what they want and what their rights are, as well as to have advocacy skills to be able to change society for the better for them, is evident in (1 and 2) above. Also, the need for people with disabilities to act as peer support and counsellors to one another (3). Sam places some of the blame on people with disabilities because he maintains they do not educate people without disabilities about their needs (4, 5 & 6). He also alludes to the fact that because people with disabilities are hidden and marginalised, (6, 7, & 8) the rest of society rarely has the opportunity to get to know and understand them and their needs (4,5,8 &16). He therefore advocates ways of promoting this integration (9, 10, 11, 12, 13, 14, 15).]

Lessons learnt from Sam

What does Sam's story tell us? It obviously tells us many things that I know will seep into and rest upon and within the hearts and minds of those who have read it. Hopefully those poignant and thought provoking aspects of his story will return to us either to haunt or challenge us to rise up and do what we should be doing as advocates for the cause and rights of people with disabilities.

I will conclude this chapter by attempting to summarise the key issues that Sam's narrative raises about what went wrong in his process of habilitation⁹. These points form the sand and concrete from which we should manufacture the building blocks of our ethos and the "what" and "how" of that which we as specialists in human occupation profess and practise. How can we ensure that we provide the optimal milieu for the many Sam's and Khulu's we meet on a daily basis to attain their maximum potential as interactive and contented individuals within their unique context? In order to do this we need to reflect deeply upon the following points that he makes:

- 1) The needs, dreams and aspirations of people with disabilities are no different from those of people without disabilities; only the disabled feel the emotions around these issues far more acutely, not just because of the limitations imposed by their physical and/or mental impairments but more because of the attitudinal and physical barriers of society that constantly strangle, frustrate and block their chances of realising these needs, dreams and aspirations.
- 2) There are people/professionals who are specifically trained for the purpose of facilitating people with disabilities in achieving their needs, dreams and aspirations (these include occupational therapists), but instead form part of the barricade that prevents the realisation of these needs, dreams and aspirations. What does this tell us about whom we select, what we train them to do, the attitudes we instil, and how we train them?
- 3) Structures put in place with the intention of promoting quality of life for people with disabilities often perpetuate the disability because of the people working within them.
- 4) Many professionals trained to work with people with disabilities have good intentions but are unaware that what they are doing is obstructing rather than promoting and facilitating the progress of the people they work with. Are we reflecting enough and consulting enough with those we serve, i.e. are we truly person-centred?

⁹ In the case of a child that is born with a disabling condition such as cerebral palsy, their ability to pass through the various stages of development that all children do, is undermined and made impossible by their impairments. It is thus not possible to rehabilitate them but rather to habilitate them i.e. to facilitate them in passing through the necessary phases of development that will bring them to more complete levels of independence with or without assistive devices, assistance and/or adaptations to their environments.

5) People who work together with people with disabilities to facilitate the achievement their dreams and aspirations need to be:

- gentle and caring but firm and stoical people who believe in the power of people with impairments and who are prepared to facilitate the realisation of this power;
- ruthless about knocking over physical and attitudinal barriers that stand in the way of them attaining such power and control over their lives;
- advocates and agents of changes that will optimise re-integration of people with disabilities back into an accepting and enlightened society;
- assertive, adaptable and resilient practitioners able to cope in a variety of situations and circumstances;
- able to assist others in recognising and realising their own power in the face of adversity.

Sam's story raises more questions than it answers. What is missing from, or wrong with our South African occupational therapy curriculum that needs to be added and/or removed and/or changed? Are the characteristics that we look for when selecting occupational therapists into our courses really those needed in order for practitioners to stand up to the challenges and adversities they must confront in the profession? Why does a society that is advancing so rapidly in so many material ways, advance so slowly in basic and essential humane ways?

The concluding three chapters that follow will attempt to unravel and answer some of these questions.

CHAPTER TEN

So what? How does all this affect the profession of occupational therapy in South Africa?

Route map: This chapter will now try to bring together the historical influences, acts and omissions of the developing occupational therapy child in South Africa and will show how the ideological and philosophical influences and models underpinning the profession of occupational therapy locally and globally, impacted upon the development of this child.

Introduction

It is now time to bring together, in a final synopsis, all the effects described in the preceding chapters upon the coming of age of the profession of occupational therapy in South Africa, conceived as it was by a father who was the bastard of an unhappy but fitting union between post colonialism and apartheid, and a mother whose European, expatriate roots were firmly buried in the loam of 'Home', thousands of miles across the sea from the 'savage' continent of Africa.

From this dark womb there emerged a bright and willing babe, happy to please Papa and eagerly socialised into the habits and ways of Mama. Despite its genetic makeup, this was a child with no evil intent; it was a child that wanted to please, to do good and to help those in need of its services. It developed well and thrived upon the sustenance of strict discipline, order and control that Papa insisted upon. It listened eagerly to Mama and soaked up the teachings she brought from 'Home'. And so, in its early years, it became the perfect little prototype of its parents.

As it developed and became adolescent, however, as adolescents are wont to do it started questioning Papa and Mama's teachings and realising that these teachings were not necessarily all appropriate to its needs and the needs of those it served, so a rebellion set in. But parental influence was too strong and in spite of this rebellion, it could do little more than stamp its feet and sulk.

It is now coming of age, and showing very definite signs of developing into a mature and responsible adult with some extremely valuable characteristics to take it into the future in

South Africa and the potential to become a true expert in the field of human occupation and its relationship between health and wellness in both people with disabilities and those without.

However, before I reveal this metamorphosed young adult, it is essential to take a last, microscopic gaze at those dark influences that have formed the landscape of occupational therapy's development in South Africa, so that we can either purge them from our past or discover how we can transform them into strengths that will complete this metamorphosis.

The genesis, philosophical principles and factors underpinning the early development of occupational therapy in South Africa

The historical outline provided in chapter 4 clearly shows the dilemma created by occupational therapy's parentage, birth and childhood. There appears to have been a strange mix of both controversial and contradictory dynamics working, not only upon the creation of the baby, but also upon its development into adulthood. In 1948 the National Party came into power in South Africa with a promise to preserve white power in general, but more particularly, to preserve Afrikaner power. The instrument used to implement this policy was called *apartheid*¹. Born post-colonially, just prior to the birth of the National Party and into the sinister context that was apartheid, occupational therapy's childhood was also exposed to constant parental conflicts. The *father* was empirical and positivist by nature and the *mother's* knowledge was mostly propositional and based upon a *priori* understanding, intuition and conviction arising from a staunch British and European background. Her status in the early marriage was patronised, undermined and subordinated by her *husband*, who put in place a series of restraints to coerce her into continuous submission.

This controlling-submissive combination of parenthood and development within a milieu of enforced segregation of the developing child from all but children of her own colour and culture, exposed her to a limited and homogeneous friendship ring with only fleeting and limited contact with members of other race groups. For the developing White, English-speaking, girl-child mixing with those who made up the majority of this country's

¹ See description of *apartheid* under footnote 3, page xiv in the foreword to this thesis.

population² was superficial and abnormal, therefore her understanding of them was also superficial and abnormal. Consequently she lost out on the richness that such contact could have added to both her educational and language repertoire, had she been able to freely and happily mix and play with the black and brown children of this land. The child was caught up in these conflicts and contexts and ultimately succumbed to some of the detrimental influences they exerted upon her. However, she also developed a resilience and flexibility that has become a trademark of her uniqueness when compared with her colleagues from other countries.

The purpose of this research has been to expose and explore this childhood, to extract those aspects of it that have scarred the child so that appropriate and adequate intervention can be made in order to reduce these scars, to reconstruct a new more realistic and appropriate identity, harnessing the strengths created from the past and reducing, replacing or changing the old, inappropriate and incapacitating weaknesses.

The medical model ideology

This model is fundamentally rooted within the Cartesian/Newtonian model of reality that is grounded in analytical scientific thinking with its dualistic separation of mind from body and body from family, community and social space³.

It follows a traditional (positivist-influenced) approach to research in which the proper role of the researcher is seen as one of being committed to the discovery of truth by means of reliable research instruments and rational discussion. It is prepared to offer evidence for claims it makes and to submit to the scrutiny of the research community and possesses a willingness to change its views on the basis of compelling contrary evidence⁴.

The concept of 'disinterested knowledge' is central to this approach i.e. innocent knowledge untainted by political or other agendas. This knowledge may, however, be

² Black indigenous South Africans, speaking 14 different languages.

³ Goodenough, D.(circa 2004) **How to take this Course**. Centre for Health and Global Environment Harvard Medical School.
http://www.med.harvard.edu/chge/course/introduction/how/reading_1.htm.

⁴ Ibid

used in oppressive and unethical ways for ideological ends or be market-orientated even when the researcher is aware of the abuse of the knowledge produced but regards this as outside of his/her control, the main aim being to achieve an accurate representation of reality⁵. In the quest for objectivity, with its exaggerated and reductive objectification of a humanity that is essentially subjective, the medical model suppresses the very core of what occupational therapy strives for, which is the acknowledgement of the unique and holistic subjectivity of each individual in need of its services.

Effect of the medical model upon how we perceived those we serve, how we communicate and how those we serve perceive us

Foucault (1989:xii-xiii)⁶ describes the origin of the medical gaze as follows:

*“modern medicine has fixed its own date of birth as being in the last years of the eighteenth century. Reflecting on its situation, it identifies the origin of its positivity with a return – over and above all theory- to the modest but effecting level of the perceived. In fact this supposed empiricism is not based on a rediscovery of the absolute values of the visible, nor on the predetermined rejection of systems and all their chimeras, but on a reorganisation of that manifest and secret space that opened up when a millennial **gaze** paused over men’s sufferings...At the beginning of the nineteenth century, doctors described what for centuries had remained below the threshold of the visible and expressible...it meant that the relation between the visible and invisible - which is necessary to all concrete knowledge - changed its structure, revealing through gaze and language what had previously been below and beyond their domain...A new alliance was forged between words and things enabling one to see and to say”.*

⁵ Humphries B (1997) **From critical thought to emancipatory action: Contradictory research goals**. Sociological Research online. Volume 2(1): 1-13.
<http://www.socresonline.org.uk/socresonline/2/1/3.html>

⁶ Foucault, M. Introduction. In: Foucault, M. (1989).

The origins of occupational therapy, as described in the preceding chapter, clearly show the paternalistic and controlling influence of medical doctors and psychiatrists in the development of the profession in South Africa. As such, their medical-model ideological principles have also deeply permeated the profession of occupational therapy and created a dilemma and set of oppositional forces that will be described and discussed as this chapter unfolds.

The following narrative collage attempts to summarise some of my experiences related to this objectification of humanity by the medical model:

Postcard #7: The Multiple Gaze

The medical model tends to reduce those it serves (patients) to a disease (the cerebro-vascular accident in bed 3), traumatic event (the motor vehicle accident in bed 5) or a body part (the fractured femur in bed 7). Almost everything about the individual is reduced to clinical components such as his temperature, blood count, amount and frequency of urinary and faecal eliminations, membranes, sputum and blood pressure. Essentially sterile, scientific and sanitary, it cures with medications, surgical procedures and regimens. It is disciplined, dictatorial and prescriptive where the doctor dictates and those who work under him follow his instructions. The 'patients' ⁷ who are 'treated', succumb to the prodding, probing and prescriptive assessments and treatments accompanied by the multiple gazes brought upon them in ward rounds, the secret discussions in the duty room and the intimate details written about them in their files. They have to succumb to the indignities of exposure on the examination couch or in the operating theatre, during which time the patient is either horribly aware of the indignity imposed by the gaze and the often invasive procedures that accompany it or, as that needle slips into the vein, they are mercifully reduced to a blissful, anaesthetised state of amnesia from which they awake only to imagine shamefully what and who their body might have been exposed to while they were in this state of oblivion.

I recall in the late 1970's, when I worked in the intensive care unit with people who were comatose, I would frequently find deep blue and purple bruises around the soft skin on the anterior part of the upper arm at the axilla. This was where they had been pinched to assess their level of

⁷ The term 'patient' is particularly associated with the medical model. I concede there may be a time in the life of an individual recovering from serious illness or trauma, when they are at their most vulnerable and acute stage of illness, and when they have to undergo 'treatment' as an essential component of their recovery, when the term 'patient' is applicable. However as they move out of the acute and/or critical phase of recovery and commence re-establishing control over their lives, the term 'patient' is not applicable. I am also not happy with the term "client" as it connotes a sense of buying of services which, except in private practices, should not apply to the provision of State Health Services.

consciousness through their reaction to pain on the Glasgow Coma Scale. And because the families of the victims kept asking what had caused the bruises, the pinching moved to the back of the upper arm, to make the bruises invisible to the gaze of family members.

On another occasion I recall having to make a hand splint in the operating theatre for a lady who had been badly burnt and was undergoing a debridement (cleaning away of all the dead burnt tissue and slough) under anaesthetic. She was fairly overweight and during the operation the surgeon remarked, "Shall I remove some of this adipose tissue while I'm at it?" at which most of us succumbed to laughter and giggling.

A ward round may be conducted by three or four doctors and interns, a handful of nurses and often the physiotherapist, occupational therapist, speech and language therapist and social worker i.e. give or take, anything from 8 to 15 people at a time. Typically this "team" with their white coats, stethoscopes and note books move from bed to bed, and at each bed arrange themselves in a semi-circle around the 'patient' so that s/he is literally surrounded by their gaze. Then each team member relates back to the doctor what progress or not, s/he has made during the week. The doctor may at any time request that the 'treatment' or an aspect of it be changed. Rarely, if ever, is the 'patient' requested to comment on their own experience of their 'treatment' and even if they were asked to do so it is highly unlikely they would complain about any aspect of their 'treatment' under such a multiple and intimidating gaze.

The description in the narrative above is a collage of my own experiences as a 'patient' and as an occupational therapist within the intensive care, ward round and operating theatre situation. They deliberately relate several negative incidents and do not relate the frequent positive incidents that may occur daily within the hospital and ward setting. The intention is not to undermine the beneficial work that medical doctors and other health care workers do in alleviating pain, illness and suffering under the umbrella of the medical model, but to show how, sometimes in its very correctness, it can be so incorrect and how, in its preoccupation with controlling, it loses sensitivity for the humanity of the very people it is supposed to serve.

Foucault uses Bentham's panoptic schema⁸ to illustrate the spatial partitioning that occurs within the institutional setting as a means of control and surveillance⁹. This

⁸ A panopticon is the central tower in a prison from which the guard has a clear view of all the prisoners situated in an illuminated circle around his tower, but the prisoners could not see each other or the guard. Bentham envisioned such a system for hospitals, schools, factories and barracks. [In: Fillingham, L.A. (1993). **Foucault for beginners**. Writers and Readers Publishing Inc. New York.]

⁹ Foucault, M. Panopticism. In: Foucault, M. (1977).

spatialization and gaze is everywhere we care to look in the medical setting: it can be seen in the glassed-off nurses' station or 'duty room' which overlooks the ward and from which surveillance can occur, in the two-way mirror in various therapy settings from which we observe the 'patient' while s/he is busy with an activity and where s/he is unaware of our gaze. Ironically, in the ward round, as described in the narrative above, there is a modification of this panoptic concept, it is turned inside out: instead of one medical practitioner surveying a group of 'patients' from a single vantage point, the situation is reversed and a single patient becomes the object of surveillance of a large group of practitioners. In addition the spatial partitioning of the object of observation and the observers is such that, instead of the person observed being on the outside of the central, fixed position of the gaze, they are literally surrounded by it – there are eyes everywhere - and the gaze is not directed from a level equal to theirs but trained down upon their prostrate and vulnerable bodies from an elevated and controlling position. It is difficult to believe that such a situation is not intimidating.

The clinical and scientific disciplines that are associated with the medical model are essential components in certain aspects of medical care. There is no way a surgeon could slit open the skin and underlying muscles and tissue of his patient with his scalpel, without a sound knowledge of human anatomy. In the same way, an occupational therapist could not select and apply activities to strengthen weak muscles if s/he did not have a clear understanding of the physiology of muscle action and what action and movement contributes to its strength and weakness.

There are, however, aspects of the medical model and its particular ethos that, in my opinion, run essentially contrary to everything that underpins the ethos of occupational therapy. The prescriptive-scientific and consequent disempowering and reductionistic constituents of the medical model reduce the individual to an object and victim, elevate the doctor to dictator and the other health professionals to a combination of servants and controllers carrying out the doctor's instructions. This configuration runs totally contrary to the collaborative and empowering ideology of occupational therapy in which the individual with whom the therapist works ('patient') should be viewed holistically as a unique individual with an equally unique context, who not only can contribute knowledge

about, and to, his/her recovery, but has to participate in all activities related to this process of recovery and to the therapy plan.

It is the extent of the control and power inherent within this model, which manifests itself in both the doctor and his team that is a ready catalyst for the activation of the potential for exploitation of the *patient*. As illustrated in the narrative collage above, the very nature of the medical model lends itself so easily to a controller - controlled relationship between health professional and 'patient' – that is the antithesis of the type of relationship desirable for eliciting motivation and instilling self-confidence in one whose motivation and self-confidence may have been disturbed or distorted by the effects of disease or trauma. When discussing the classical theory of sovereignty as the right of life and death, Foucault (1976:240)¹⁰ describes this as “*biopower*” of the sovereign: “*it is at the moment when the sovereign can kill that he exercises his right over life*”. It is at the moment when the patient is the most afraid for his or her life that the doctor (and team) is most powerful. The holistic ethos of occupational therapy, in which those we serve are required to take responsibility for their own progress and recovery, necessitates the creation of a relationship in which the removal of fear is paramount and the nurturing of a situation in which power is perceived to be in the hands of those being served, not the therapist, essential.

It is important here to make a distinction between the confident, efficient and truly empowering¹¹ therapist who, by the very nature of her/his therapeutic expertise, is able to manipulate the therapeutic situation so that that the person s/he serves is able to realise and seize control over their lives and thus work in partnership with the therapist in taking ownership of the course of their recovery and the therapist who lacks these qualities and abilities and therefore incorrectly manipulates the therapeutic situation and the one s/he serves and/or is manipulated by the one s/he serves and/or, and, as such, is of little if any value to the therapeutic or recovery process.

¹⁰ Foucault, M. 17th March 1976. In: Bertani, M. & Fontana, A. (Editors). (1980) Picador, New York.

¹¹ Empowering, in this sense, does not imply a patronisation of therapist over those s/he serves but rather a true negotiated empowerment in which the two work together, where one member of the partnership has been disadvantaged by illness and/or injury which has compromised occupational independence, and the other has certain knowledge and skills to bring about and plan together the best course of action for recovery of independence, quality of life and self esteem.

Exposure to physical trauma or illness which results in the loss of ability to perform normal daily occupations will, by its very nature, initially reduce the individual to a situation of physical powerlessness in which others have to take over these occupations for them. The effects of this may concomitantly create a sense of psychological powerlessness and dependency. It is in this situation that the individual becomes most susceptible to exploitation. Ideally, it is in the retention of the non-physical elements such as motivation, confidence and lack of fear and in the 'giving back' of the ability to perform some or all of these lost daily occupations that the process of holistic empowerment commences. It is in that quintessential moment when the individual perceives him/herself to be able to carry out certain occupations and/or to tell others what and how to do things for them that empowerment progresses from control together-with-therapist to control-by-self.

The medical model's effect upon occupational therapy's epistemology

In feminist epistemology, the knower is situated in particular relationships to what is known and to other knowers. What is known and the manner in which it is known thus reflects the situation or perspective of the knower¹². Thus, in the context of the medical model, the therapist as knower is the recipient of second-hand and selected knowledge from the doctor as knower. The manner in which the medical model knowledge is known by the therapist is subordinated by the dominance of the doctor who controls that knowledge, and allows the therapist access to practise only within certain parameters of that knowledge. This was revealed in Chapter 4, for example, in the statutes of the male-doctor-dominated South African Medical and Dental Council (1974:754), regarding their control over the training of occupational therapists i.e. *"...to control, and to exercise authority in respect of all matters affecting the training of persons in, and the manner of the exercise of the practices pursued in connection with, the diagnosis, treatment or prevention of physical or mental defects, illnesses or deficiencies in man"*¹³.

¹² Andersen, E. (2003). **Feminist Epistemology and Philosophy of Science**. Stanford Encyclopaedia of Philosophy. <http://plato.stanford.edu/entries/feminism-epistemology>.

¹³ SAMDC: Medical, Dental and Supplementary Health Professions Act, 1974 (Act 56 of 1974)(As amended) – Statutes of the Republic of South Africa – Medicine, Dentistry and Pharmacy pages 753-757.

These different kinds of situatedness can affect knowledge in several ways. They influence the knowers' access to information and the terms in which they represent what they know, and they impact upon the forms of the knowledge (articulate/implicit, formal/informal, and so on). The relative weights given to different epistemic values, such as their predictive power, consilience, amount, sources, and kinds of evidence required before a claim is accepted, are affected by who is situated where within a particular knower/ known relationship. Situatedness thus affects the manner in which the knower assesses which claims are significant or important¹⁴. Early knowledge emerging and emanating from the everyday experiences of occupational therapists in an action-research-type situation where subjective experience is important would therefore typically be perceived as inferior to that expected of the empirically driven medical model.

Mattingly and Flemming¹⁵, in their discussion on biomedicine and the many potent metaphors around which it is organised, maintain that the most significant of these metaphors is the least obvious one, which is buried in the notion of the biomechanical body in which the body becomes a machine and in which the body-machine is distinct from the mind, but houses the mind. A practice that views the 'patient' as a machine, with an assembly of parts that malfunction and need fixing, can more easily conceive the body mechanistically once it is separated from the mind.

Wilcock¹⁶ maintains that limitations have been imposed upon occupational therapy because of its origin in the medical profession. It has perceived itself as part of a larger endeavour masterminded by the medical discipline. Throughout its life in the 20th century, in South Africa and in the rest of the world, occupational therapy has been subservient to medicine, which has dominated other health professions by limiting, subordinating and excluding them through its control over the work situation, its professional autonomy within the medical division of labour (and Medical and Dental Council), and occupational sovereignty over related and neighbouring professions. This unbalanced relationship has decisively influenced the growth, development and

¹⁴ Andersen, E. (2003).

¹⁵ Mattingly, C. & Flemming, M.H. Occupational Therapy as a two-body practice: the body as machine. In: Mattingly, C. & Flemming, M.H. (1994).

¹⁶ Wilcock, A. Occupational therapy's relationship with occupation and health. In: Wilcock, A. (Editor). (1998).

changing focus of occupational therapy and is largely responsible for the medical science orientation of occupational therapy's knowledge base throughout the world.

Although our medical forefathers conceived of our origins, this foresight was quite possibly also born of a desperation and frustration that, in spite of the application of tried and tested medical interventions to achieve healing with some of their 'patients', they were unable to progress beyond a certain point of recovery. So, to put it simply, something else was needed, where those 'cases' with whom conventional medical interventions were no longer successful, could be removed from the medical 'gaze' and placed under a more patient, more fundamental and less scientific gaze. Implicit in this arrangement is a tacit acknowledgement of a curative force beyond the scientifically oriented one.

This new gaze from the occupational therapist would, during its development, with time, exposure and experience of witnessing the pain and suffering caused through disability as well as the courage and resilience shown in the face of such adversity, learn to intricately analyse and understand the importance of human occupation in remediating, rehabilitating and preventing factors leading to impairment and illness. It would also develop an appreciation of the impact of the various types of physical and mental impairment upon human occupation. This was a gaze that was not reductive or resident within a truth linked to the sovereign power of the empirical gaze that turns darkness into light¹⁷. This was a gaze that would reflect back out of the eyes of the one being spoken to and communicate mutual respect and understanding; a gaze that would wonder at the changes that would take place in those once immobilised by depression and loss of confidence, once they participated in meaningful occupations and thereby rediscovered their abilities. A gaze that saw much more than the light that came from the darkness. The gaze that became insight.

The effect of the medical model upon health care in South Africa

The medical model permeated health care in South Africa throughout the apartheid era and still has a strong, although diminished, hold within the post-apartheid system of health care. The Western medical model was brought to this country by the colonists.

¹⁷ Foucault, M. Introduction. In: Foucault, M. (1989).

During the early colonial period, public health activities were initiated either to combat diseases that affected the European settlers such as malaria and sleeping sickness or as attempts to maintain a healthier workforce¹⁸. Either way, its motives were aimed at retention of sovereignty over people's health and maintenance of a segregationary system of health provision. As such, it positioned itself within a first world level of superiority over the third-world circumstances within which it found itself having to work.

Towards the end of the colonial period, the pattern in which health care had developed here was largely modelled on the system of health care in industrialised countries where the emphasis focused on expensive high-technology and urban-based curative care in large urban hospitals, with care providers who were trained in the Western model.

The enormous contributions that the Western medical model made to developing countries cannot be under-estimated, but it also had shortcomings in addition to those described above, the most serious of these being the manner in which it almost entirely ignores the underlying socio-economic and political causes of health problems¹⁹. Furthermore, it implicitly holds in contempt the various cultural idiosyncrasies related to health and wellness that are inherent in the indigenous cultures of South Africa. It has, for example, up until the introduction of the post-apartheid health system in this country, not shown respect for the methods of traditional healing used by these cultures, nor attempted to understand them, nor tried to gain greater insight into how the belief systems around witchcraft and ancestral worship exerted an influence on health and wellness.

Vignette #6: Bewitched

In my family's early years in Swaziland, my father was one of a handful of doctors working there. He worked daily and in many settings with the Swazi people and was the personal doctor to old King Sobhuza (and many of his hundred odd wives) at the time. I recall him telling a story of a young man who, he said, "had no apparent physiological disorder" but who was dying because he had been bewitched. In spite of every possible medical intervention to save his life, the man did die. It is in situations such as this where a greater understanding of the culture would perhaps have been more useful than all the knowledge of medicine.

¹⁸ Werner, D. & Saunders, D. The historical failures and accomplishments of the western medical model in the third world. In: Werner, D. & Saunders, D. (Editors). (1997).

¹⁹ Ibid

The effect of the medical model upon people with disabilities

When disability studies came to life in the late 1970's, led by disabled activists in Britain, its pioneers made it clear that they were unable to emerge within the bounds of any discipline which had percolated out of studies by non-disabled academics, not only because non-disabled people could not voice the needs or aspirations of disabled people but also because, up until this time, health professionals involved in the care of disabled people had excluded the disabled from any discussion about their needs and aspirations, concentrating their patronising and controlling focus instead on the 'cure', 'care' and weaknesses of people with disabilities²⁰.

Disabled activists did not want disability studies to emerge within the curative bounds of the medical model quite simply because the fundamental intention of medicine was to *"restore the impaired to the greatest approximation of 'normality'". At very best the frustrated medical approach to curing disability spawned its own new solution in the new discipline of rehabilitation*" (Finkelstein, 1998:4)²¹. What an indictment of rehabilitation and, indirectly, of occupational therapy! But the main and justified concern of the disabled activists of that time was the fact that they were excluded from input into the training of health and rehabilitation professionals. As a result they were denied the opportunity to influence the practice, ethics and philosophy of rehabilitation²². This is a particular area of neglect by those custodians of occupational therapy's education (of which I am one) and urgently needs to be addressed in the transformation and updating of the occupational therapy curriculum in this country.

Dynamics emanating from occupational therapy's association with the medical model, parallels with the rest of the world

Wilcock²³ describes five dynamics which emanate from occupational therapy's association with the medical model and which shaped its development in America, all of which are applicable to the South African context, and as such need to be applied to this background. They are:

²⁰ Finkelstein, V. Emancipating disability studies. In: Shakespeare, T. (Editor). (1998).

²¹ Ibid

²² Ibid

²³ Wilcock, A. Occupational therapy's relationship with occupation and health. In: Wilcock, A. (Editor) (1998).

- Prescription
- The feminine gender bias
- Patronage
- The pursuit of professionalism
- Scientific reductionism

Prescription One of the founding presidents of the American National Society of Occupational therapy was a Dr Dunton, who gained his medical colleagues' support in mandating the prescription or referral of 'patients' to receive occupational therapy. This cast occupational therapists in the role of a technician who would carry out treatment under the doctor's instruction. He described occupational therapists as "*technical assistants whom the physicians would direct*"²⁴. At the time doctors were predominantly men and occupational therapists were almost entirely women, hence the division of labour followed the traditional gendered patterns in terms of which the men conceptualised and controlled treatment and the women carried it out under their instruction²⁵.

You will recall from chapter 4 that this hegemony by doctors over prescription and referral of 'patients' to occupational therapists is echoed in the South African history. In addition, in the SAMDC Rules (1976:312) specifying the Acts or Omissions in respect of which disciplinary steps could be taken by the Professional Board for Occupational Therapy, it was stipulated that: "*the treatment of any patient (may not occur) unless that patient has been referred by a registered medical practitioner*"²⁶.

As a result of this, the intellectual foundations of occupational therapy's epistemology were grounded in the medical model and came from 'outside' of the profession. This, and the history of occupational therapy as a prescribed therapy, inhibited the adequate research or development of its unique view of, and contribution to, health and wellness. The restrictions imposed by this prescription led to stagnation and preoccupation with the application of technical skills and a curative focus at the expense of exploring the

²⁴ Ibid:188

²⁵ Ibid

²⁶ SAMDC (1976) Regulations Relating to the Constitution, Functions, Powers and Duties of the Professional Board for Occupational Therapy. No.R2287, 3December 1976, page 312.

multitude of other aspects of human occupation that relate to health and wellness, either as prevention of illness or promotion of wellness and quality of life.

Thus it was that all that daily knowledge that was being generated through observation and hands-on experience by occupational therapists in hundreds of situations was being suppressed by the overriding domination of the medical model which stipulated mostly what we could and could not know. In the early years, occupational therapists were so indoctrinated into believing that everything they did had to follow the prescribed constraints of the medically dictated *acts and omissions*, that all those aspects of occupational therapy that have little or *nothing* to do with medicine (such as insight, self-actualisation, spiritual growth, motivation, self-respect, pride and quality of life) became situated on a lower level of importance than the medical aspects such as weak muscles, poor balance and poor joint range. The question that we now have to ask is, are they indeed of secondary importance?

Gender Bias Locally and globally, occupational therapy was initially identified as a women's profession. Throughout its history prior to the commencement of training at the first historically black university in 1977²⁷, occupational therapy training has only produced a handful of male occupational therapists. It is suggested that one of the reasons for this gender bias is that the profession emerged during and after the first and second world wars, when most men had been sent to the frontlines and thus it was left to women to take on the rehabilitation of the injured when they were sent home disabled. However, neither this explanation nor the widely held assumption that women have a special aptitude for such work²⁸ accounts for the fact that the proportion of males working as occupational therapists currently remains low.

²⁷ See chapter 4, footnote 14 and 15 page 69.

²⁸ The first Historically Black University to commence training occupational therapists was the Medical University of South Africa (MEDUNSA) and thereafter the University of Durban-Westville followed by the University of the Western Cape. A combination of factors probably led to there being a higher number of male applications and acceptance into occupational therapy training at these universities. Possibly because of their disadvantaged educational background, many African males had inadequate academic points to get into medicine but were attracted by a medically oriented profession. In addition, many had an interest in and concern for assisting their own communities where rehabilitation had been absent or very limited. Another possible factor was an absence of bias for working in an, until then, predominantly female led profession because such men had not been tainted by the Eurocentric gender orientation to various professions.

Rather, this is attributable to the fact that in the early years of the profession work was gender-biased and women received knowledge that was permitted by men who defined our roles and prescribed what we could and could not know or do when it came to work outside of the domestic sphere of housewife and mother. And occupational therapy, like nursing, fell into that realm of providing a 'technical' support service to back up and serve the male-dominated medical profession.

It may sound like common sense that the saving of lives should take precedence over the provision of quality of life, but if the life which is saved is severely impaired and there are no policies and strategies in place to provide such a person with every opportunity to regain quality of life, a serious question arises as to the morality of saving a life if it is doomed to a quality-less existence²⁹. Shannon in Wilcock (1998)³⁰ describes the medical model as being committed to a science and technology, which in turn is committed to prolonging life, but ignores the conditions that make that life worth living.

Wilcock (1998:190)³¹ describes the early pioneers as *"the female founders who blazed a trail for 'less educated and advantaged women' (and who) were, on the whole, from upper middle class, well-educated (backgrounds), and immersed in the advancement of careers for women."* In spite of their emancipatory leanings, they still accepted subordination to medicine in a manner characteristic of the gender segregation that was a given of the upper middle class domesticity of that day.

It is significant that South Africa's early occupational therapy pioneers mirror those in America, in that while they had excellent intentions of providing better quality of life for people with disabilities, in this country there were several factors militating against this. Firstly, the Health System of those days only provided rehabilitation in urban and tertiary care settings, thus excluding the vast majority of those in need in rural and primary health care settings. In addition, being white and advantaged women, OTs lacked both the ability to communicate with, and have insight into, the specific cultural and contextual needs of the majority of disabled people in South Africa at the time.

²⁹ Jagoe, K. (circa 1984). **Condemned to Live**. Disabled People South Africa. Bulletin.

³⁰ Wilcock, A. (1998). **An occupational perspective of health**. Slack. New Jersey.

³¹ Ibid

Patronage Wilcock (1998:191)³² describes a situation very similar to that in South Africa: “*the most obvious symbol of medical authority was the long-standing practice of having physicians at the head of occupational therapy professional associations*”. With the exception of only one occupational therapist, Eleanor Clark Slagle, for the first three decades of its existence, the presidents of the American National Society of Occupational Therapists were men, mostly from the medical profession. You will recall that, in Chapter 4, the South African Association of Occupational Therapists was under similar patronage for the first 22 years of its existence. This lack of autonomy from external control undermined both the acquisition by occupational therapy in South Africa of professional status and the ability to spread our wings and spread our knowledge base beyond the restrictive confines of the empirical medical model and the power that was wielded over us by the creators of this model and by the male dominated, dictatorial, narrow-minded and autocratic government of the time.

However, as Wilcock³³ reminds us, this patronage did have its benefits by securing recognition and acceptance of the young ‘speciality’ of occupational therapy. There was also growth through referral of clients, and the founding fathers were allies in excluding potential competitors. This professional interdependence also provided a boundary from which to negotiate other boundaries with health workers from other disciplines, such as physiotherapists, speech therapists, nurses and social workers, where there was potential for conflict over division of labour.

Professionalism³⁴ The striving of occupational therapy towards professionalisation, based on a medical model, has led to a mental struggle for occupational therapists in that it blurred their conceptualisation of their role and where they fitted into the health care delivery system³⁵. It is partly this which, I believe, has had a strong influence upon the profession’s inability to create a clear and definite identity.

Eighteenth century physicians sought to free themselves from linking the diagnosis to the patient’s experiences of his/her illness i.e. the phenomenology thereof. Since then

³² Ibid

³³ Ibid

³⁴ Wilcock, A. (1998).

³⁵ Griffin, S.D. (1988) **Conflicts in professional practice**. Australian Occupational Therapy Journal. Volume 35(1):5-12.

medical professionals have depended less and less upon the patients' own perceptions and understanding of their illnesses, resulting in an excessive dependence upon more precise (and thus professional) information gleaned from diagnostic instruments and laboratory tests, and little dependence upon the less reliable (unprofessional) data gleaned from the patients' own reports³⁶. The modern approach to health care, and certainly the approach of the current government of South Africa, rejects professionalism in favour of community participation; it rejects elitist academic knowledge in favour of lay understanding and replaces the consulting room/clinic with a preference for community-based interventions³⁷.

From a South African perspective, there has always been the conflict generated by the influence of this model over the grounding of the profession versus the need for occupational therapists to be constantly considering the totality (psychological, physical, spiritual and contextual) and individuality of those they are trained to assist. It is impossible to reduce the impact of a severe physical or mental impairment upon the psyche, soma, soul and context of an individual to a quantity, or to separate these four elements and only concentrate on one or the other when working together with people with physical and/or mental disabilities.

Occupational therapy is about providing quality of life to people whose health and wellness has been compromised or threatened by some or other occupational dysfunction or risk of dysfunction. And as we break out of our chains, we realise that it may even go beyond this as well, but I stray from the point. Thus, with very few exceptions, occupational therapy cannot reduce its search for answers to quantifications and objectifications of the subjects it works together with. It is by nature a profession that requires a critical, holistic and multi-faceted qualitative and quantitative approach to finding the truth about the unique link between individuals and their quest for health and wellness through occupation.

³⁶ Mattingly, C. & Flemming, M.H. Occupational Therapy as a two-body practice: the body as machine. In: Mattingly, C. & Flemming, M.H. (1994).

³⁷ Swartz, L. & Gibson, K. The 'old' versus the 'new' in South African community psychology: the quest for appropriate change. In: Seedat, M. Duncan, N. & Lazarus, S. (Editors). (2001).

Professionalism includes accountability to the interests of the public (communities) one serves. But in the apartheid days this was largely restricted to a particular bounded grouping of individuals, resulting in an ethically and morally warped professionalism. Professionalisation can be viewed as an occupational strategy to maintain monopoly over certain privileges and rewards. The professional dominance of doctors is clearly grounded in the possession of a body of knowledge, and it is the element of possession that is crucial in exercising professional power. Professions are not fixed social entities but are structured forms of occupational strategy. These strategies and how they are exercised can be seen in the class, work and status situation of occupations.³⁸ Occupational therapy's status, in its formative years in South Africa, was reduced to that of 'technician' and 'supplementary to medicine'. It is now essential that it rises from these ashes and establishes itself firmly in its *own* identity, a partner not a supplement!

The articulation of our knowledge in acceptable scientific terms has resulted in disagreement and controversy within the profession, but Mocellin (1996)³⁹ maintains that occupational therapy is placing the cart before the horse by focussing its debate on the meaning of scientific jargon rather than questioning the credibility of what it is that occupational therapists need to be scientific about. We are far more concerned with the in-depth and rich descriptions that are given by people with disabilities, and which will inform our approach to better meeting their needs, than we are with knowing how many flexions of the elbow it will take, against how much resistance, to strengthen the biceps muscle from an Oxford standard 3 to one of 4, although both kinds of knowledge are obviously important to us.

I argue emphatically that the verbal or recorded description of the pain and suffering of an individual who has undergone severe disabling trauma or illness cannot be captured in cold, clinical, scientific terminology, or quantified on a scale of *never, sometimes, always*. It is so unique to each individual that it requires the deep, gut-wrenching and subjective revelations, which only that single individual can yield up. It is an "*I shat myself*" rather than an "*I had a bowel movement*" revelation and these revelations are, by their very nature, essentially subjective and emotive. This is precisely why they have,

³⁸ Turner, B.S. and Samson, C. Professions Knowledge and Power. In: Turner, B.S. and Samson, C. (Editors). (1996).

³⁹ Mocellin, G. (1996). **Occupational therapy: A critical overview: Part 2**. British Journal of Occupational Therapy. Volume 59 (1):11-16.

until recently, been scorned by the wider scientific world, and certainly by the medical world as lacking validity but they have a resounding human validity because they reveal the untainted, real and unique human voice that occupational therapists must be listening to.

Reductionism⁴⁰ Throughout and because of its history, occupational therapy has always been under pressure from the medical profession to produce scientific proof of its effectiveness as a requirement for gaining their recognition of its value. Certainly in countries such as America, Canada, UK and Australia, occupational therapists appear to have welcomed this pressure from medicine to be scientific and these countries have produced large numbers of research publications to alleviate the pressure and justify the existence of occupational therapy as a profession.

In South Africa, therapists have been particularly poor at producing scientific proof of their effectiveness. I speculate that this is attributable to several factors. For example, South African occupational therapists have been under greater work pressure than those from countries in the so-called developed world, due to lower numbers of therapists and a very high consumer load, leading to the time available to do research always being in short supply. Early occupational therapy training also did not promote adequate research capacity amongst its graduates. Thus, a combination of research ignorance, lack of time, the presence of a critical and domineering research ambience and an innate sense that the social and holistic nature of their practice did not lend itself exclusively to the empirical hegemony that existed in its early development, resulted in a paucity of by occupational therapists in the early history of the profession in South Africa. This is unfortunate but reversible.

In addition to this, there are certain *a priori* facts about occupational therapy that do not require the complicated intervention of research to provide evidence for its efficacy. As Wilcock (1998:193)⁴¹ puts it “...the basic philosophy that actual ‘doing’ provides people with a vehicle for growth, development, achievement and health” does not require empirical proof, it is a fact, just as breathing is a fact. Shannon⁴² maintains that the

⁴⁰ Wilcock, A. (1998).

⁴¹ Wilcock (1998):193

⁴² Shannon, P.D. (1977). **The derailment of occupational therapy.** The American Journal of Occupational Therapy. Volume 31(4): 229-234.

adherence to medical science's reductionistic model was what derailed occupational therapy. Although it may not have resulted in a complete derailment, because of the rebellious nature of the early therapists, it has, I believe, caused South African occupational therapists to become preoccupied with the symptomatic and curative/remedial component of occupational therapy rather than focussing on our more important role in prevention, promotion, maintenance and rehabilitation and, of particular importance now in South Africa, also palliative programmes for individuals in terminal stages of HIV&AIDS.

Early therapy was largely geared towards using activity/occupation for remedial purposes such as to strengthen muscles, improve concentration or reduce depression with quite a lot of focus on providing assistive devices and adaptations to the environment to make it more accessible, but the crucial aspect of really integrating people with disabilities back into society as happy and productive individuals, remains generally elusive in current occupational therapy practice. There has, over the years, also been a coming and going of emphasis between curative and rehabilitative focus in this country as will be revealed in extracts from my focus groups.

In an interview for the *Journal of Occupational Science*⁴³, the famous American occupational therapist, Elizabeth Yerxa⁴⁴, was asked how she came to her vision of occupational science and her answer was that it had arisen through her exposure to clinical practice and how the persistent emphasis on the medical hierarchy, and its authoritarianism within clinical settings, was inconsistent with our aim of trying to prepare people with profound disabilities to go out into society and be self-directed. She expressed concern about how people who had been very successful as 'patients' in the clinical setting were not coping in the community. She was also struck by the manner in which even the very people purporting to facilitate their integration marginalised disabled people⁴⁵.

⁴³ *Journal of Occupational Science*, August 2004, Vol. 11, No 2: 80-84

⁴⁴ Elizabeth Yerxa is recognised worldwide as one of occupational therapy's visionaries and pioneers. She was one of the founders of occupational science and her writings on occupational therapy have influenced many therapists throughout the world. She has practised as an OT for 50 years and is still practising.

⁴⁵ Meltzer, P. (2004) **Occupational Profile: an interview with Elizabeth Yerxa**. *Journal of Occupational Science*. Volume 11(2):80-84.

Supporting Data

The still dominant influence of the medical model over South African occupational therapists, and the contradiction and conflict this causes with their own need to find ways to articulate a more appropriate epistemology for the profession, was revealed in most of the focus groups⁴⁶ conducted to obtain data for this thesis. Some of the participants were Afrikaans first language speakers and hence there are some grammatical errors, which I have left unedited.

Examples

➤ Focus Group 1:

Response to the question ***Do you believe that the role and scope of occupational therapy has changed over the past 20 years?***

Participant X: I think in essence [pause] the essence of OT has become more defined (1) over the last 20 years, that it's definitely (2)[pause] it's the role of the functioning and all that so to me its become more defined (3) but with it becoming more defined (4) it also increased the scope and (has) gone into different areas and different things...um...[pauses] (5) ja, sometimes I just wonder where we're going to stop because it gets almost too wide (6) (audible agreement from one or two of the group) and maybe that is one of the reasons why OT is not always known (7) and one of the reasons...what we were talking about marketing (alludes to earlier discussion on need to market OT better) of OT s and so on because you can't market everything of OT it's not ...[trails off](8).

Comment 1:

In this extract Participant X demonstrates a lack of clarity regarding exactly what has changed within the profession over the past 20 years. For example she mentions three times how the role and scope of OT has become more defined (1, 2 and 3) but contradicts this by comment (4) in which she states that, in becoming more defined, the role and scope has become too wide (5 and 6) (implying a lack of definition), a fact which is supported by others in the group. This lack of clarity is further evident in her inability to clearly articulate herself in statement (2, 3 & 5, underlined) and finally the trailing off at the end of the sentence (5). An allusion to the identity - just so much to try to get over in the process (8).

⁴⁶ Details of focus groups can be found in Chapter 2 pages 19 and 26-27.

Participant Y: ...sometimes I wonder maybe it's also the shift from the medical model (5) to including more the social stuff (6)...that...because occupational performance is so much social um (7) [pauses] and our uniqueness is so much more visible (8)...you know people can see that we can make a difference (9) so that's why they will ask for the services of OTs.

Comment 2:

This confusion continues in Participant Y's response, which shows uncertainty about whether there has been a shift from the medical model (5) to a social model, but even the manner in which she refers to the social model (6 & 7) is indicative of uncertainty and even possibly a certain amount of disdain i.e. (6) she then pauses and continues on a completely different topic (8). It is also unclear how occupational therapy's uniqueness has become more visible or that this will also make people see how we can make a difference (9) simply because we have shifted from a medical model to a social model.

Participant X: But I think people (10a) are scared to make the shift (11)... I think there's still quite a bit of people (10b) who feel comfortable in the medical model (12) ...

Comment 3:

A final telling comment by Participant X who, by referring to occupational therapists as "people", (10a & b) distances herself from those who are scared to make a shift from the medical model (11). She also feels that there are quite a few occupational therapists (10b) who are still content that the medical model (12) is appropriate for OT.

Much later on in the discussion, Participant Y reveals her own preference for the medical model in the following extract from her response to the question: ***Do you think that as OTs in Africa we have something unique to offer the rest of the OT world?***

Researcher [referring to a previous comment by Y about the ability of South African occupational therapists to apply better clinical reasoning compared to e.g. British OTs]: *So you say their...the South Africans' clinical reasoning is better?* [Inaudible.]

Respondent Y: Ja...ja (R: apologises for interrupting Y.) ...they (South African OTs) could reason about the condition and think about the symptoms and why the symptoms are like this ...so and you know and then without resources (13) or whatever ...you know they *can go on (14) ...and maybe they* go one step back (15) and... um... because we also use the medical model (16) and maybe others (17) use the social model much more.... like for instance...many...many places (referring again to other countries) use this Kielhofner⁴⁷ model ... and because he's got many assessments...he's got many treatment protocols (18)...you can actually treat any patient with any condition (19) but the focus is not on the condition and sometimes when the condition is not a typical condition (20) um they (OTs from other countries)...um struggle to cope (21). I think that's what we [South African OTs] can offer: it's a better integration between the medical and the social model (22).

Comment 4:

What stands out in this extract is the abundant use of medical model terminology or 'speak' (red font) that Y uses. Notice how this tends to objectify the individual into a condition rather than a person. Y alludes to the flexibility of South African OTs* and their ability to work under difficult conditions, (see 13,14 and 15) ; she states that Western countries (17) make use of treatment protocols (18), in which *treatment* for various conditions is set out rather like a menu with time limits for achievement, making it easy to treat typical common conditions (19) but not so easy (21) to treat individuals with complicated diagnoses (20) which South African OTs are able to do by virtue of their flexibility/adaptability and an apparent superior ability to integrate the medical and social models(22). There is the implication in the last sentence (22) that South African OTs appear to be situated between the medical and social models.

➤ Focus Group 2:

Response to the question: ***Do you believe that the role and scope of occupational therapy has changed over the past 20 years?***

Participant X: Mmm...no I think there's been a huge change over the last 20 years when I think I actually did OT to do rehab and I don't know if I've seen a rehab case in the last 5 years (1). Early discharge, decreased resources (1a), perhaps even a lack of caring (2) or lack of rehab specialists.. I see a greater trend towards palliative care (3)

⁴⁷ Kielhofner G, (2002) Model of Human Occupation. This model provides a framework for therapeutic reasoning whereby the therapist uses a theory to understand the client and develop a therapeutic plan together with the client. It is client centred and therefore unlike the protocol intervention strategy.

and as one of my colleagues have just said a move from IPC (4) [Independent Performance Components i.e. symptoms] to OPAs (5)[Occupational Performance Areas] I also see far less role for us in the hospitals because of the acuteness (6) ...I think that we are needed out in the community but I'm not sure that we've got the resources (1a) ...and maybe with community service (compulsory) that will increase. And I think we are going to have a much greater role with family whether those are the orphans (7) or the extended family ...I think we're going to have a HUGE role in education (8).

Comment 5:

(1) Refers to the fact that she trained to do rehabilitation but her role during the past 5 years has been mostly involved in remedial/curative work (medical model). This is mostly due to rapid discharge of people from hospitals, lack of resources (1a) and there is a concern that there is possibly even a lack of caring (2) amongst some health care workers. IPCs (4) refers to those components that OTs have to remediate e.g. improve muscle strength, before they can commence with rehabilitation which is improving OPAs (5) i.e. independence in functions such as dressing. This is actually a contradiction of what she says previously i.e. she acknowledges a move from curative emphasis to rehabilitation in (4) and (5) But there is still an implication that OTs are more involved in the curative/medical model role by virtue of what she says in (1) above. The reference to acuteness (6) and palliative care (3) is alluding to the large numbers of HIV&AIDS sufferers/orphans being seen by OTs in SA Hospitals.

In the last sentence (8) X spells out how occupational therapists should be involved i.e. rehabilitation and working in communities rather than in hospitals/institutions but by virtue of her preceding comments this is not what is happening. 'The orphans' (7) in this sentence is again alluding to HIV&AIDS.

Participant Y: Partly in response to X above... no I think that...that... in spite of the legislation (1) being in place for community development of primary health care approach..I think that it's not really happening on the ground (2) and I think that that to a large extent is actually rather hindering the progress of the profession. And I think also that another thing that's important is that there's been a swinging backwards and forwards (3) is that we've gone from a more social approach to care in our own area to a more very medical approach (4) and I think that if we're moving into community we're going to have to adopt another kind of ideology to (5) ensure that it's broader than just health (6)... because I think that the issues around occupational performance are much greater than just health issues (7) And obviously that affects training and effects resources... All kinds of things.

Comment 6:

Y is expressing concern about the fact that government legislates (1) for a primary health care approach with concomitant community involvement but that the infrastructure is not being put in place (2) hence the policy cannot be properly implemented by OTs.

The implication here (3 and 4) is that we have oscillated between medical and social models (4) but are now returning back to a medical model approach (4); however there now appears to be a need for a new approach/model/ideology (5) [Echoes of Y's comments in focus group 1 above see comment 2]. The allusion to this move as encompassing more than just health (6) demonstrates the awareness that occupational therapy can extend beyond those with physical and psychiatric disabilities to those at risk of these. It also alludes to the necessity to move to a wellness approach (7) However there is also the suggestion that maybe there is more to OT than simply the medical and social ideologies (5).

Respondent X: But health is not full of...there's no dignity in health anymore (1) and I think that ...I think that's what's for me so sad is that people come in...when you go to see them in a hospital, they seem to be a thing rather than a person (2) and people (3) deal with their symptoms rather than their issues (4) because there is pressure to get them out. (5). You just need to patch them together a bit (6) and then march them out (7) and hope to God (13) that somebody else (8) is going to look after them out there (9) wherever that is (10)....and that families are absolutely (11)...don't have the resources to do that (12).

Comment 7:

X is referring here to the current trend of rapid discharge of people from hospitals before they are properly rehabilitated (1), but what the rest of this statement conveys is that the current system of rapid discharge lends itself to the medical model's objectification (2) of the individual under care. The "people" in (3) refers to medical professionals. The perceived focus is on curative (symptomatic treatment) (4) rather than more holistic rehabilitation that is implied in the words "their issues". The people (4) referred to in this statement could be all health professionals or doctors. Given the generalised nature of the statement, I would think it refers to all health care workers. Yet again there is reference to the rapid discharge implied in (5) and how this impacts on care. The last statement is filled with sarcasm and a sense of the desperation about the circumstances in which therapists in some SA hospitals find themselves: the inability to provide adequate intervention (6), the authoritarianism within these institutes (7), the lack of human resources and the lack of adequate backup care once individuals are discharged (8). The

'somebody else' referred to in this statement will probably be the families. This calls on superhuman intervention (13) to deal with the needs. The enormity of the need in the community cannot be adequately conceived or expressed (9) and (10), nor the ability to conceive of the problems of the families (11) of the people 'patched up' and 'marched out' of the hospitals, which is left hanging in this incomplete sentence (11) and the referral again to lack of resources (12).

➤ Focus Group 3:

Respondent D ... think there has been a shift in our thinking (1) about our profession (1) um...I think um...we're working according to much, like Z said, stronger theoretical frameworks, I mean if I recall in the early days of OT there wasn't anything like that (2)...um I think we've become much more patient centred (3)... ah with an emphasis on the client's needs empowering (4) the client rather than this maternalistic type of approach (5) that you generally have.... I also think there's been a shift from...from... hospital... out of hospital into communities...I don't think it's done (6). but I think within the primary health care approach..I also think that there has been a move from a focus on pathology and condition to a focus on human occupation and function (7) ...I think that ...I also think there's been a shift from a medical to a social model (8). And something which I...I've got a dilemma with (9)...myself at the moment is that...it feels to me as if we're nearly moving back to the pathology model (10).. 'cos people outside of OT are doing so many of the things that we say are occupational therapy (15). ...and it..it's...I don't know, I can't formulate it properly but (11)...it's as if we're forcing back into working just with ...ah...patients...whereas a couple of years ago...probably 10, 15 years ago there was a lot of emphasis on promotive and preventive type of work that the OT would do.... and it feels to me as tho' we're actually losing that (12), everybody is doing it and we're sort of. ...getting stuck just with patients ...I...I'm not formulating (13) it well but it's all sort of a sense of reversing (14) [chuckle] a little bit. I don't know if anybody else has had that sort of feeling?

Comment 8:

D's comments are particularly interesting because they echo much of what has been said by respondents taken from other focus groups. She indicates, like others, an insecurity about exactly where occupational therapy is by referring to all the shifts it has made i.e. (3), (4), (6), (7) and (8). But there is also a concern from this respondent that OT in South Africa is returning to the medical model (10) and (14). What is also evident is the inability to articulate exactly where it is that OT in South Africa positions itself (9), (11), (12), (13). Again, this echoes a sense of uncertainty about our identity and direction.

The lack of adequate primary health care and community infrastructure at the time of the focus groups was resulting in a situation in hospitals that perpetuated a medical model approach by therapists because of the need to remediate symptoms rather than get on with the important task of rehabilitation and integration of people with disabilities. What is also of significance to this discussion is the respondent's referral to the maternalistic type of approach (5), which could be alluding to the feminine version of the paternalistic medical model approach in which there is a softer version of prescribing to the 'patient'. There is also a reference to the fact that other people (health professionals?) are poaching from occupational therapy's territory (15).

There are five particular points echoed in all three focus group responses discussed above. They are:

- An acknowledgement of change but a lack of clarity or inability to articulate clearly how occupational therapy has changed over the past 20 years.
- A perception/belief that South African occupational therapy is oscillating between the medical and social models but that it is still more aligned to the medical model.
- The lack of adequate primary health care and community infrastructure at the time of the focus groups was resulting in a situation in hospitals which perpetuated a medical model approach by the therapists because of the need to remediate/cure symptoms, rather than get on with the important task of rehabilitation and integration of people back into their communities.
- Difficulty in articulating occupational therapy's identity.
- Lack of clarity about the particular direction the profession is taking in South Africa.

Vignette # 7: Trapped where we feel most competent!

At the May 2004 Congress of the Occupational Therapy Association of South Africa (OTASA) in Cape Town, one of the delegates (a middle-aged and respected therapist in private practice) said, in response to one of the papers delivered, that she felt it was "a group feeling that we are trapped in the old medical model because that's where we feel most competent". I wrote it down on my conference pad because it struck me as yet another echo of what had emerged from my focus group analyses.

Because of the ideological situation of control over their development, occupational therapists were, in the early days, denied epistemic authority. As a result we are a complex progeny; fumbling in our attempt to define our role and purpose as occupational therapists in Africa. Our past has marginalised us as a profession and turned us into an 'only child' impoverished by being denied the joy and enrichment of sharing that development with our brothers and sisters of other race groups . It is now, as we break away from this influence, that we need to be adamant about establishing a firm epistemological basis that more appropriately reflects the truth and situation of our profession.

To suggest that reorganisation of the health care system with greater emphasis on, for example, community and social medicine, at the cost of abandoning scientific clinical medicine, is a false and defensive either/or dichotomy. It is not a question of choice between one and the other - it is a question of the exclusiveness of one over the other, and about the need for balance⁴⁸ and a change of emphasis according to various contexts. It is also about a need to de-emphasise the medical model ideology in favour of more appropriate ideologies such as that espoused in the social model of disability.

The concluding chapters will show how occupational therapy has metamorphosed in adulthood although remnants of the past still cling doggedly to our attire as has been revealed in the examples above and in preceding chapters. They will attempt to offer some direction as to how this balance and change in ideology can be incorporated into the occupational therapy curriculum of the future.

⁴⁸ Geiger, J. (1974) **Educational implications of changing methods of health care provision.** The American Journal of Diseases in Children. April: 554-559.

CHAPTER ELEVEN

Reconstructing an Occupational Therapy Identity

Route map: This chapter will commence rounding off the thesis by discussing specifically how the developmental history of the profession of occupational therapy has affected its identity. It will make suggestions on how to reconstruct the occupational therapy identity to make it more appropriate and unambiguous.

Introduction

As the work for this thesis has progressed, analysis and engagement with the various sets of my data have made me more and more aware of the failure to date of occupational therapy as a profession in South Africa to adequately articulate and position itself with an identity that is *sui generis*, more particularly, one incorporates the unique ingredient of that which is quintessentially of this land and her peoples. The thesis's exploration of occupational therapy's history has thrown light on some of the reasons for this. The best way I can illustrate this is by using a hypothetical analogy/story.

Letter # 4: Sipho's Story - an analogy:

Sipho was born in Africa. Had all gone according to plan, his development would have taken place in the wide open, sun-filled plains of this continent, running, jumping, falling over and climbing the seemingly insurmountable geographical, climatic, socio-economic and political challenges and obstacles in his way. He would have been brought up to believe in the inseparable importance of his fellow human beings to himself and how his existence was moulded through his relationships with them. He would have soaked up the sun, freedom and richness of his own enormous classroom with Mother Nature and the sages of his community as his teachers. He would have carried with him a wealth of knowledge that no mortar and brick classroom and bespectacled, chalk-in-hand, teacher could ever have brought to him. He would have become himself because he would have had the freedom, environment and philosophical umbilical cord of his mother country to ensure this.

Sadly orphaned at birth through unforeseen political circumstances, Sipho was adopted by a European couple desperate for a child. They bundled him up in blankets and whisked him off to the cold climes of Europe. Here he grew up under loving and proud parents but very strict and authoritarian ones. His life was confined to doing and being what his father and mother wanted him to be. Instead of lying naked as a child upon a goat skin on the floor and freely kicking his limbs and discovering how to move his body, he spent long hours trussed up in blankets and clothing to ward off the cold. Instead of growing up with his age-mates from the village and running free in his uMutsha¹, soaking in the teachings of his environment and sitting around the fire in the evening and listening to the stories and tales of the old and wise men of his village as they sipped on their uTshwala², he was confined to the rigid brick and mortar classroom of Europe, where what he learnt and how he learnt was dictated to him by his parents, teachers and the society in which he was brought up. Instead of becoming one with his community he learnt to become separated from it because he lived in a little flat high up in the sky with no siblings and he was constantly told not to make a noise or disturb the people next door and to mind his own business. Every now and then he would open a book and there would be revealed either a picture or a story about a huge continent called Africa, and each time he did this, deep down in his very soul he would feel the yearnings to be free and to go home and rediscover himself.

If we substitute the story of Sipho's development analogously with that of occupational therapy South Africa, the same dichotomy resulting from being uprooted and made to develop in an alien environment appears.

Occupational therapy in South Africa has been made to develop in an environment that is mostly alien to the real needs of its people and its own ideology. Almost everything that this ideology espouses runs counter to the medical model and apartheid ideologies under which that we were forced to grow up. The climate of exclusivity of the time ensured that we would exclude adequate knowledge about the African cultures and the lived experiences of people with disabilities from our epistemology. So the relationship between the occupational therapist and those s/he had to know was one-sided and hegemonic.

¹ A traditional loin covering worn by boys and men, usually made of the hide and sometimes the tails of wild animals or goats, mostly worn in rural communities and not so common today as even young rural boys are moving to wear more western attire.

² Zulu beer made from mealies or corn.

Reconstructing our identity

We need to reconstruct our identity, not an identity that rejects the positive and good things that our history with its Eurocentric and colonial dominance has taught and brought us, but one that rejects the primacy of Euro-American values and its philosophical assumptions about human beings and rather places the experiences of those 'other-than-European', at the centre of our discourse³.

We need to reconstruct an identity that is purely ours, and one that unambiguously reflects our particular philosophy, a philosophy which, though influenced by our Western colleagues, is situated within the unique context of Africa. This implies that we take all those core generic principles and values that leaders in our profession from Africa and across the entire world have developed and proudly espoused over the decades of our existence, and fuse those particular components that the African context demands of us, to create a profession that is unique from any other.

This research has revealed areas that particularly require our attention if we are to reconstruct an identity that unambiguously reflects our particular ideology, one which is not dominated by contradictory principles and one which is acceptable to all those we serve in this country. The following points are of relevance in the reconstruction of this identity:

Taking ownership of our unique knowledge system

In the past, the knowledge we were soaking up in our day-to-day contacts with those in need of our services was perceived as inferior knowledge because it was not gleaned using the rigid scientific methodologies of our positivist sovereigns, a scientific methodology that frequently repressed its subtext of desire not just to reflect but also to reproduce the world in a particular political way. Ager (1991) maintains that the postured objectivity of such a science is a secret vehicle for an imperial subjectivity that becomes more potent the more it disguises itself in the garb of a disinterested quest for knowledge and science for science' sake⁴. In the same way indigenous knowledge is viewed as

³ Butchart, A. (1997). **Objects without Origins: Foucault in South African Socio-Medical Science**. South African Journal of Psychology; Volume 27(2): 101-110.

⁴ Agger, B. Writing the social. In: Agger, B. (1991).

less systematic and empirical than scientific or rational knowledge, and because of past colonial and apartheid domination, so Africans have, to a large extent, internalised the derogatory discourse of their former masters on the African ways of life and modes of thought⁵. The lack of acknowledgement of the importance of the experience of disability as portrayed by the disabled expert is emphasised by the social model of disability⁶ and such lack of acknowledgement and recognition is also indicative of the denigration of this particular form of knowledge.

The true knowledge of occupational therapy, the 'gut feel,' intuitive, experiential knowledge gained from the daily use of occupation as a vehicle for improved health was subjugated by the powerful and controlling influences under which it was developing. In this way we too have partially internalised the discourses of our oppressors, which has added to the confusion surrounding our identity. Acknowledging the importance of our own knowledge, also the knowledge of the disabled expert and African indigenous knowledge, belief and value systems within the reconstruction of our identity will not only contribute to depicting the holistic and inclusive nature of our ideology but will also contribute to the creation of a positive discourse which is owned by all occupational therapists and the people we serve.

The dangers of modelling ourselves upon models

As long as I can remember, from way back in the 1960's when I studied occupational therapy, and now having passed through the role of practitioner to lecturer, the ideology of occupational therapy in this country has always essentially viewed the human being as:

- an holistic being, a totality or trilogy of body (soma), mind (psyche) and spirit (soul) that lives and survives within a specific environment and context, with these four aspects inextricably linked in such a way that if any one of these is adversely affected, it will impact upon all the others.
- being unique and possessing the ability to control and choose their own lifestyles and destinies.

⁵ Hountondji, P.J. Knowledge appropriation in a postcolonial context. In: Odora Hoppers, C.A. (Editor). (2002).

⁶ Baily, K. Learning more from the social model: linking experience, participation and knowledge production. In: Barnes, C. & Mercer, G. (Editors). (2004).

- occupational beings who survive, thrive and actualise their potential through being able to perform various occupations of life.

And when an individual becomes disabled by physical and/or psychological illness or trauma:

- The harmony and balance between body, mind and spirit becomes disturbed,
- this impacts, to a greater or lesser extent, upon the person's ability to perform the various occupations essential for their survival and quality of life.
- participation in selected and carefully structured occupations can be used to restore physical and mental functions and harmony to the trilogy of body, mind and spirit.
- the enabling, through occupation, of these physical and mental functions, which are essential for the individual's independence, restores much more than the independence of the individual concerned.

And now more recently we are realising that even in the absence of illness or disability, occupation is essential to health and wellness. Thus, an individual who is perfectly healthy and who loses his job, or works so hard he cannot participate in leisure occupations, predictably may become depressed or over-stressed which in turn will impact upon his level of wellness.

Thus, given the medical model's focus on illness and its tendency to objectify, mechanise and reduce the individual to *patient* and to the status of body parts and pathological conditions, and given its prescriptive, controlling nature, it is impossible to fully reconcile this ideology with the one I have described above. And yet we did, and we do, on a daily basis. We have allowed this ideology literally to rule our lives at the expense of our unique identity and our ability to realise our true potential when it is unfettered by this burden.

Models are a helpful guideline in structuring our thoughts, orientating us to a particular discourse or way of thinking, and assisting us in planning our programmes. They provide security and order in a working environment that often contains elements of insecurity and disorder; they form the basis around which we can argue certain points in favour of a particular mode of enabling intervention or *treatment* (where applicable). But they also

create boxes and compartments into which we try and fit our intervention programmes, or those who are in need of our services, and sometimes the fit does not entirely match.

We must be cautious about allowing ourselves to become too obsessed with, or bound by, the use of models in the same way that our Western and American colleagues seem to have become. Models have become the *in thing* of the new millennium, and new models are being developed with bewildering regularity. I am concerned that their proliferation is gradually creating a new discourse and elitism against which knowledge systems are judged and either accepted or marginalised. Kielhofner's⁷ model of human occupation is a typical example. Not to know about or make use of this model in modern day occupational therapy, especially in the Western world, would be considered naïve and outdated by most Western occupational therapists.

Over-affiliation to a particular model suggests compartmentalisation, and our profession does not lend itself to compartmentalisation. We have to be eclectic by virtue of the complexity of the circumstances and problems surrounding the individuals whom we serve. A particular compartment that may work for one, may not for another. The very nature of our work, the diversity of cultures of the people we work with, and frequently also a complex array of complications and circumstances⁸ surrounding many of those we serve make it necessary to utilise an eclectic mix of ideas and information. Circumstances such as this make it impossible to become entrenched in models, many of which have been designed for Western, European populations in which those referred for occupational therapy rarely, rather than regularly, would present with the complex mix of diagnostic and contextual challenges that face South African occupational therapists.

⁷ Developed in the early 1970's and refined until now, Gary Kielhofner's (2002a) Model of Human Occupation is arguably one of the most used and talked about models in occupational therapy in the Western world today.

⁸ Many of the people referred for occupational therapy in public hospitals in South Africa have a complex mix of conditions and circumstances that frequently complicate what would normally require conventional occupational therapy approaches to their recovery programmes. For example, the individual referred to OT may have been admitted with gunshot wounds resulting in paraplegia but which have caused other serious complications (e.g. pneumothorax, peritonitis, and a radial nerve injury to the right dominant arm). In addition, the individual concerned is unemployed and lives in a one-roomed shack in an informal settlement. He has a grade 3 education, his parents have passed away and he has lost contact with his siblings. It is quite possible that on top of all this, he is also HIV positive.

If we are to develop and use models they should be created specifically to be inclusive rather than exclusive and they should be malleable so that they can be adapted to suit various cultures and contexts nationally and internationally. Models created for the Western world, or any other world for that matter, cannot simply be imported and used lock, stock and barrel in the South African context. Fransen⁹ maintains that, especially working in community-based rehabilitation settings, no one model can serve the world given the diversity of communities within it. Thus, models that are not sufficiently adaptable or flexible to allow for their modification for our unique use, and to the variety of cultures and situations we work in should be avoided. Models that can be tailored to the various cultural, ideological and socio-economic and socio-political circumstances are more appropriate.

Creating our own particular discourse

Vignette # 8: Trapped in a particular discourse

"What is particularly revealing to me about the influence that medical model discourse has upon us is that, throughout the writing of this thesis, I have had to consciously stop myself from making use of words that were born in the medical model- words such as patients, practice, treatment, condition, pathology, clinical and normal. And I am acutely aware that when I do the final read of the thesis before submitting it that I will have to use a fine tooth comb to ensure that some of these words have not slipped into places where they should not be."

We need to generate a language that is designed to be inclusive and uplifting, one that articulates the importance of human relationships as part of a contracting process. However, Taylor¹⁰ warns us that the more inclusive language of relationship has become more and more the rhetoric of the 'powerful', causing many oppressed people to view this language with suspicion. A typical example is the word 'partnership', which has been bandied about, particularly in South Africa, and used as a means to channel funds from wealthy donor countries into projects for disadvantaged populations, but experience shows that these arrangements often results in misappropriation of such funds by stealthy and powerful persons within the partnerships.

⁹ Fransen, H. Challenges for occupational therapy in community-based rehabilitation. In: Kronenberg, F. Algado, S. & Pollard, N. (Editors) (2005).

¹⁰ Taylor, J. (2002). The poverty of partnerships. The Community Development Resource Association (CDRA) Nugget 2002:1- 4. <http://www.cdrea.org.za>.

Townsend and Whiteford¹¹ remind us that even the word *occupation* is narrowly understood as pertaining to work, and can also be perceived as pertaining to taking control of, as in a military occupation. They take a radical, political stance on the word *occupation* and assign to it a broader meaning than its immediate association with economic activity or control evokes. They advocate a participatory or people-centred¹² approach which places occupational therapy's emphasis on listening, collaborating, animating, facilitating, coaching, enabling, developing, partnering and other empowerment orientated processes in which one works *with* individuals and populations. In order to do this it is imperative that we use a language that does the very things the above terms stipulate. The developmental nature of occupational therapy's progress in South Africa at present necessitates the construction of what Taylor¹³ refers to as a nuanced vocabulary of relationship terms.

There also needs to be far more interactive dialogue between South African occupational therapists to encourage discussion around the reconstruction of our identity and the language and discourse that should characterise it. This has to be the first phase before we move into a global phase when we can have interactive dialogue with our colleagues in other countries, but we must not be dissuaded or deflected from constructing our own nuances and terms, in accordance with the principles and factors previously alluded to in this chapter, that will promote the development of an enabling environment. Such dialogue will nurture the "*fresh ideas and new perspectives*" that Elizabeth Yerxa maintains are essential for fulfilling the need for a generative theory in occupational science and dialogue¹⁴. Whatever we do in our identity reconstruction process, occupational therapists have to reject and unlearn the use of the disempowering, controlling and prescriptive language of the medical model. How we speak reflects how we act and if we develop a discourse that reflects confidence, sensitivity to others, a determination to achieve goals and respect for others' opinions in

¹¹ Townsend, E. & Whiteford, G. A participatory occupational justice framework: Population – based processes of practice. In: Kronenberg, F. Algado, S. and Pollard N (Editors) (2005).

¹² The common term for this is client-centered, I have a problem with the use of the word *client* because it denotes a pecuniary transactional exchange between therapist and client, which although existent in the process of service delivery on whatever level, should not become the focus of centeredness and thus to me the term people-centered is a more inclusive one.

¹³ Taylor J (2002).

¹⁴ Lentin P (2004) **Occupational terminology: Interactive dialogue**. Journal of Occupational Science. Volume 11(2):85-86.

setting those goals, it will become the vocal expression and reflection of how we intend to act when we work with others.

In addition to creating a new and more acceptable discourse through which to express our profession, we need to recognise the crucial importance of the diversity of languages in South Africa, and whilst I am not suggesting we have to learn all the ethnic languages of our country, I think it should be mandatory for all occupational therapy curricula in this country to include an African language module. The choice of which language should be left to the student registered for the course, and should be based upon the languages spoken in the region where one is likely to work or upon selecting a more commonly/broadly used language such as isiZulu or Xhosa. There can be nothing more disempowering to an occupational therapist than trying to enable someone with whom s/he is unable to properly communicate. And yet most occupational therapists in this country cannot speak an African language. How can we enable, facilitate and contribute to empowering people if we cannot adequately communicate with them?

Setting aside from the obstacles faced by those unable to speak an African language, even for occupational therapists that speak one fluently there are barriers to communication. Amongst these are the perceived status of the therapist, the race of the therapist, the educational level and the socio-economic status of the person being assisted¹⁵. The less educated and the poorer the person, the more likely they are to feel barriers in communicating with the occupational therapist. In addition to this, there are idioms, nuances and terms used in most African languages that denote respect (or the lack of it) or may be ambiguous. There are also specific forms of *respectful* language between men and men, men and women, and children and adults, for which several thousand respect-words (hlonipha¹⁶) are used¹⁷. Thus, care has to be taken to avoid using words that may be considered insulting.

¹⁵ Ellis, C. Cross cultural aspects of depression. In: Ellis, C. (2004).

¹⁶ Ukuhlonipha is the isiZulu term that refers to the custom of respect demonstrated between African people and which carries with it a special language or use of words, dependent upon who the people are who are communicating.

¹⁷ Ellis, C. Difficulties in communication. In: Ellis, C. (2004).

Moving away from illness towards wellness

One of the most important moves that we have to make to reconstruct our new identity is to move away from the focus on illness and curative intervention towards a promotive and preventive focus on wellness. In the early days of occupational therapy most of our efforts centred on helping persons with disabling illness and trauma to regain function and independence. The years of research by occupational therapists worldwide and developing insight into the importance and benefits of occupation to health have changed the limitedness of this early focus. The broader concept of '*enabling occupation*', which encompasses a wide range of participatory, holistic and contextual practices that are essentially the opposite of the paternalistic, reductionistic, standardised care-giving practices in which others have things done to or for them and where they do not hold control over their destiny, is more in line with the new focus¹⁸. The enabling approach favours the participation of the individual over an autocratic, hierarchical therapist-patient relationship. Enabling approaches may be used in communities or populations where there is no illness but where there is a risk of developing illness, or where the quality of life and the ability to actualise potential of otherwise *well* individuals is threatened.

Closely linked to this concept of enabling is that of occupational justice, which presumes that humans are irrevocably occupational in nature, that they are unique and indispensable regardless of how marginalised they may be, and it argues in favour of the realisation of the occupational potential of all people as a means towards greater health of individuals, populations, communities and nations¹⁹. Occupational injustice occurs when individuals, communities, populations or nations are in some or other way prevented from realising their occupational potential²⁰.

Examples of occupational injustice are occupational apartheid, an oppressive condition in which there is a monopoly over occupational options available to one group at the

¹⁸ Townsend, E. & Whiteford, G. A participatory occupational justice framework: Population-based processes of practice. In: Kronenberg, F. Algado, S. and Pollard N (Editors) (2005). and Townsend, E. (1999). **Enabling occupation in the 21st Century: Making good intentions a reality**. Australian Occupational Therapy Journal. Volume 46:147-159.

¹⁹ Wood, W. Hooper, B. & Womack, J. Reflections on occupational justice as a sub-text of occupation-centred education. In Kronenberg, F. Algado, S. & Pollard, N. (Editors). (2005).

²⁰ *ibid*

expense of another²¹. Another form of occupational injustice, and one that is particularly relevant to our country and continent is occupational deprivation, which refers to situations in which the ability to participate in and fulfil needs for meaningful and health-promoting occupations is in some way denied, for example imprisonment, unemployment and confinement in refugee camps.

Perhaps the most important argument in the movement away from illness to wellness is that it follows the social model ideology in which people with disabilities, once recovered from the effects of their disabling illness or trauma, are no longer ill and therefore do not require curative or remedial interventions. The process of enablement thus focuses on facilitating their reintegration back into their communities and old lifestyles and ensuring their ability to participate in meaningful occupations.

Becoming advocates and agents of change

One of the most important and crucial roles that the state-of-the-art occupational therapist must play is that of being an advocate for change in terms of policy implementation and situations in which occupational injustice may occur. The post-apartheid South African Government has systematically put in place policies (including rights-based policies) and legislation to redress the inequities in service provision that was the legacy of the apartheid government and extend inclusive services across the nation. These measures include policies and legislation specifically affecting people with disabilities²² that will be discussed in more detail in chapter 12.

It is in the monitoring of the implementation of this legislation and these policies that occupational therapists must be particularly alert, which in turn calls for a sound knowledge of the legislation and policies as well an understanding of what procedures to follow if problems in implementation occur. Occupational therapists in community

²¹ Abelenda, J. Kielhofner, G. Suaraz-Balcazar, Y. & Kielhofner, K. A model of human occupation as a conceptual tool for understanding and addressing occupational apartheid. In: Kronenberg, F. Algado, S. & Pollard, N. (Editors). (2005).

²² Philpott, S. (2006). **Policies and legislation relating to disabled people in South Africa.** Notes compiled for the community orientation programme for Audiology Occupational Therapy and Speech and Language Therapy Students at the University of KwaZulu-Natal. Durban.

settings are also ideally placed to facilitate the implementation of foundation documents such as the Integrated National Disability Strategy²³.

The new occupational therapist in South Africa has to be an agent for change and to be such s/he needs not only the knowledge but the attitude and personality to be able to pinpoint areas where change is required to ensure proper integration of people with disabilities back into society and to detect instances of occupational injustice, and to take appropriate steps towards effecting the necessary changes.

South African occupational therapists of today need to be acutely aware of the socio-political status of the communities they work in and how this affects the occupational status of individuals whose wellness is at risk as a result of it. The occupational therapist should be able to work together with threatened members of such communities and advocate for change where this is required.

Acknowledging and utilising the expertise of people with disabilities

As revealed in the previous chapters of this thesis, occupational therapists, both in their training, and in their day-to-day work situations have failed to adequately harness the expert voice of people with disabilities and/or their caregivers to inform their work. We are guilty of the arrogance of believing that we speak with authority because of the intensity of our theoretical training in matters about the human body and mind and the various diseases and traumas that disable the body and mind: we have made the inexcusable mistake of listening more closely to the medical and our own non-disabled voices than to the voice of the disabled person. Surely the most expert consultants in the field of a specific disability are those persons who possess the impairments that result in the disability? Yet we have failed to adequately acknowledge this crucial source of knowledge in both the educational training and practice spheres of our profession.

Disabled activists, following a social model approach, have done much to change a situation in which people without disabilities have been the spokespersons for those with disabilities. The increasing recognition that the client has a part to play in decisions

²³ **Integrated National Disability Strategy.** (November 1997). The White Paper of the Office of the Deputy President. Rustica Press. Republic of South Africa.

about his therapy requires that we train occupational therapists in such a way that they value and respect the 'client as expert of lived experience'²⁴.

Moving from institution-based to community-based intervention

The apartheid government concentrated its health care focus on tertiary care that is very curatively oriented. As a consequence occupational therapy training curricula tended to focus both theory and practical training to meet the needs of such a service. Thus many senior occupational therapists in management positions today were trained within this particular orientation. While they acknowledge the need for a community and primary health care focus, the old orientation makes it difficult for some of them to grasp and become involved in all that this entails. It is literally a case of the heart being willing but the spirit being weak.

The new government has shifted this focus from tertiary care to primary health care, and although there are delays in implementing such a service, it is now, with the implementation of compulsory community service for newly qualified therapists, starting to show signs of important developments in this area. The hospital or institutional setting is so far removed from the grassroots integration process for someone who is recently disabled. It is an abnormal and disempowering place for anyone to try to come to terms with their disability and thus, except for initial basic curative therapy such as improving performance components, applying specialised techniques and commencing elementary self care, it should not be considered as a locus for rehabilitation, prevention and promotion programmes.

Obviously, the best way to facilitate the integration of someone with a disability back into his or her community is to do it in the particular community where the person lives. Here one can realistically evaluate obstacles to integration and attainment of independence, and utilise one's specialised knowledge and advocacy and agency skills to overcome those obstacles in the real life situation. The bulk of occupational therapy service should be a hands-on, out-there, in the real world service, not one that works within the sanitised and unnatural confines of a hospital or institutional setting. There is

²⁴ Linegar, M. (2005). **Changing mindsets through 'lived experience': An exploratory study of a partnership in occupational therapy education.** A dissertation submitted for a Masters Degree in Occupational Therapy, University of Cape Town, South Africa.

unquestionably a place for institutional service but this should not form the focus of our energy, concentration and resources.

The World Federation of Occupational Therapists acknowledges the existence of approximately 600 million people with disabilities worldwide, and an estimated 80% of these live with their families in the communities of developing countries. These numbers continue to increase in both the developing and developed world due to war, injuries, substance abuse, environmental damage, HIV/AIDS, malnutrition and other chronic diseases. Medical advances that prolong age also contribute to the swelling of these numbers²⁵. Such a situation screams out to us to get out of our Sanitary Towers²⁶, leaving only a remnant of our services there, and to move out into the communities where our services can be correctly actualised.

The WFOT report cited above maintains that, in spite of the progress made in the advancement of community-based rehabilitation over the past 25 years, only an estimated 2% of the 480 million people living in 'developing countries' currently receive such assistance²⁷. That surely must send out a clear message to us.

The South African context of community-based practice will in many cases require that one work within disadvantaged communities where poverty and poverty-related health risks are prevalent. People with disabilities are particularly vulnerable in such settings and thus a focus on alleviating poverty through income generating projects would be an important aspect of the role of occupational therapists in this context. In addition there is a need for the empowerment of people with disabilities in such settings to be able to take control of their financial situation so that those with whom they live do not exploit their disability grant or any other income for uses other than those dictated by the person with a disability²⁸.

²⁵ Kronenberg F, Fransen H & Pollard N (2005b) **The WFOT position paper on community-based rehabilitation: A call upon the profession to engage with people affected by occupational apartheid.** The WFOT Bulletin. Volume 51:5-13.

²⁶ i.e. tertiary health care institutional settings.

²⁷ Kronenberg et al (2005b)

²⁸ Refer back to Chapter 9 page 201 where Sam reveals a trend in low-income areas for the entire family to live off one disability grant.

Fransen²⁹ pinpoints several issues related to the shift in the vision of community-based rehabilitation³⁰ (CBR) that are relevant and reflect many of the findings of this thesis. She recommends the shift in emphasis from the medical model to a socio-political model of disability, which would lead to an expanding focus beyond rehabilitation to more multi-sectoral approaches. There should also be an increased emphasis on human rights and equal opportunities for people with disabilities and CBR should be considered an essential part of community development. Therapists working in CBR settings should have effective management skills to deal not only with the day-to-day management issues, but to manage projects and to transfer management skills to those empowered to start their own income-generating projects.

Being truly people-centred³¹ is the focal point of reconstructing our identity

This point, I know, will evoke the indignant response from many colleagues: *'But of course we are people-centred!'* My response to this anticipated umbrage is that, if we were really, properly, people-centred, how is it that the very people we are trained to serve are not always happy with how we serve them, and are not always enabled by the interventions we apply to supposedly enable them? But to put this into fairer perspective, we need to take a microscopic look at what it is to be truly people-centred and at what we have left out of our training that, to put it crassly, leaves us rather half-baked in this area. Of course, by the very nature of their work, occupational therapists care for people, and view them holistically and respect their right to decide on their own destiny etcetera, but I am of the opinion that there are still substantial gaps in our training for preparing our future occupational therapists to become effectively people-centred in the way they should be in this country.

The Canadian Association of Occupational Therapy³² that gave birth to the concept of client-centeredness define it as "collaborative and partnership approaches used in

²⁹ Fransen, H. Challenges for occupational therapy in community-based rehabilitation. In: Kronenberg, F. Algado, S. & Pollard, N. (Editors) (2005).

³⁰ The term Community Based Rehabilitation is a contentious one and one which I think requires interactive dialogue amongst therapists to change because the work we do in communities is not always of a rehabilitative nature and this term brings with it the baggage of illness.

³¹ As previously discussed (see footnote 12 page 241) I prefer the term people-centred to the more commonly used client-centred.

³² Canadian Association of Occupational Therapists. **Enabling occupation: An occupational therapy perspective.** (1997). CAOT Publications ACE; Ottawa On.

enabling occupation with clients who may be individuals, groups, agencies, governments, corporations or others". And according to Precin (2002:1)³³ *"it is a method of practice in which the person receiving services directs the focus and nature of intervention"*. Kielhofner (2002b:163)³⁴ describes client-centeredness as *"a process that respects, informs and enables clients to become active partners in determining the goals and strategies of therapy"*. The above definitions provide a broad idea of what a client- or people-centred approach is supposed to be. I have some minor disagreements with aspects of these definitions but to discuss these now would be a digression, so let me extract core aspects within them for brief consideration. The underlined words are the critical aspects of this process and, in spite of the fact that they denote such good, clean, commonsense occupational therapy handling, they are loaded with broader meaning, nuance and innuendo that require a particular focus in the training of occupational therapists.

The process, for example, of empowering someone who has been severely physically and emotionally traumatised to direct the focus and nature of their own recovery is not a simple task. It is one that requires a whole subset of skills and knowledge bases. Enabling people to become active partners in directing their recovery and integration process requires not only giving them the skills to do this, but might also require changing attitudes and increasing the store of knowledge that the person themselves, their families, loved ones, communities and policy makers are able to draw on. So the whole concept of people-centeredness is a highly complex one that requires special attention in the restructuring of our occupational therapy curriculum to create our reconstructed identity. The implication in the Canadian definition that people-centeredness involves everyone and all organisations with which the occupational therapist will come into contact gestures towards another vast area of training that needs to be built into the existing occupational therapy curriculum.

Another concern I have about this concept relates to who we select into occupational therapy training. The stereotype of the gentle, caring, person wanting to 'do good' for others and 'make them independent' again carries with it the risk of selecting into

³³ Precin, P. (2002). Client-centred reasoning: Narratives of people with mental illness. Butterworth-Heinemann. Boston.

³⁴ Kielhofner G. Thinking with theory: A framework for therapeutic reasoning. In: Kielhofner, G. (2002b).

courses individuals whose motives for doing occupational therapy may be more self-serving than people-serving. The nature of the work of occupational therapy lends itself to *feeling good about doing good* but occupational therapy as I am describing it here may require being quite tough on those we serve; it will require an assertiveness that confronts socio-political issues that stand in the way of enabling the people we serve and it will certainly require watching them struggle, often against considerable pain and suffering, to reach their goals. People-centred people thus have to be tough, resilient and assertive. They have to be good listeners, sensitive to, and acutely aware of, the little idiosyncrasies of the lives of the individuals and communities that they work with and in, and which often go undetected by the untrained eye. How does one train an eye to look for these?

Research done by Sumison and Smyth³⁵ to determine which therapist barriers prevent client-centred practice suggests that there are, indeed, substantial barriers, the most common being the differing goals of the client and the therapist. Most frequently these differences become an impediment because the therapist's own values and beliefs prevent them from accepting the client's goals. Imagine how this must impact in a country with the cultural diversity of ours?

Shifting from a fixation on the 'therapist' role to more encompassing roles

The word therapist also comes rather loaded with medical model innuendo. It implies a doing by one to another. As such it only really describes the role the occupational therapist may play in the acute '*illness*' phase of the recovery process of someone who has become disabled. It does not encompass the other roles the occupational therapist also takes on in community settings and settings where the people we work with are no longer ill. Examples of these roles are those of facilitator, collaborator, partner, mediator, advocate, agent, consultant, and programme manager. It thus also raises the question as to whether the title occupational *therapist* truly reflects the nature of our work!

³⁵ Sumison, T. & Smyth, G. (2000). **Barriers to client-centeredness and their resolution.** Canadian Journal of Occupational Therapy. February, Volume 67(1):15-21

Shifting focus from individual one-on-one contact to group and community contact

The profession's past situatedness in the institutional setting has caused us to become more oriented to one-on-one contact with those we serve. Obviously such contact with those we serve will always be a necessity for occupational therapists and is the ideal. However, given the socio-economic situation in South Africa and the enormity of the communities in need of our services, we need to learn to work more effectively with large groups of people and entire communities, and to work together with supportive health workers who can help us reach greater numbers than we would be able to on our own or on a one-on-one basis. I believe that this ability is already highly developed amongst many South African occupational therapists but it needs to become integral to our training.

Shifting research focus

Our origins have dictated a proclivity for the positivist, quantitative approach to research by virtue of the loaded validity that the medical world appears to give to this type of research on their hierarchical scale of best evidence.³⁶ With a history such as ours, it is obvious that this type of research is also generally oppositional to our ideology. This does not mean that there is no place for quantitative positivist research, especially in institutional, curative settings. However, given the holistic and person-centred nature of occupational therapy's ideology, it is obvious that a qualitative research focus is more appropriate. Our current leanings should generally be towards an emancipatory, critical research focus as we try to make up for all the time we have lost in not listening to the voices of those we are trained to serve.

We should be liberating ourselves from the fetters of the past and soaking up the richness of the voices in our future: the voices of communities, the individual voices of those who tell us openly and subjectively what occupation means to them and their health and wellness; our own voices - these too are filled with a wealth of experiential knowledge that can enlighten and guide us in the reconstruction of our identity.

³⁶ Refer back to Chapter 5 page 106 for the table on hierarchical levels of best evidence.

Maintaining a global orientation

Since the demise of apartheid and the institution of a democratically elected government in South Africa, a new confidence and pride has started to emerge in many South Africans. This can be seen in the proudly South African logos appearing on most South African products, in the collective pride we take when one of us, or one of our sports teams, is successful on the international stage. Whether it be our rugby team winning the World Cup, Charlize Theron receiving an Oscar, 'Yesterday' and 'Tsotsi'³⁷ being nominated for Oscars or Makhaya Ntini taking out the Australian cricket team with six wickets for 22 runs, we are all starting to take enormous collective joy and pride in the achievements of our people. There is a new breed of South African getting ready to pave our way into what promises to be a bright future. Many of the young people matriculating out of our mixed schools now sound more or less the same, they have a single distinctive South African accent. If one closes one's eyes and listens to them speak it is almost impossible to detect what race they are. In the past this was very easy to detect. Indian, black, mixed race and white South Africans all had (and many still do have) distinctive accents and ways of talking, but this is changing as cultures meet and mingle.

I believe that a combination of factors such as integrated schooling where enculturation takes place, access to the rest of the world through television and the internet, the eventual freedom to mix with and have friends or lovers of any race group, and this collective pride and love of our country is resulting in a type of fusion of cultures into a distinctive South African nationality. There will always be particular cultural and religious distinctions but there will also be a typical South African-ness, a *braaivleis*, *rugby/soccer*, *bunnychows and landrovers*³⁸ joviality and collectivity that will eventually make it easier to redesign the occupational therapy curriculum, but this will take time, and until then we have to be particularly sensitive to placing the experiences of those '*other than European*', at the centre of our discourse.

³⁷ At time of writing this, it is two days away from the Oscar awards ceremony so I was unable to give the final verdict, here's hoping Tsotsi wins!

³⁸ A Bunny chow is a dish invented by Indian café owners in the South African port city of Durban that consists of a hollowed out half or quarter loaf of white bread filled with delicious spicy meat curry or curried beans. The words in italics are adapted from an old Chevrolet advertisement that used similar words and was sung to a distinctive tune; the original words were '*braaivleis, rugby, sunny skies and Chevrolet*'.

The world is moving into a global phase in which it is expected that we will witness escalations in the frequency and gravity of changes that will effect society, and particularly the health of our humans, fauna and flora worldwide. In order to deal with these changes in a collective and responsible manner we will have to actively collaborate with our professional colleagues nationally and internationally³⁹. In this context, we need to be able to establish a universal discourse regarding health, one that articulates core and generic principles and values that know no borders, but are universally agreed upon. This, however, should not detract from the creation of an own and unique discourse regarding the health and wellness of our particular diversity of cultures within our particularly unique country and continent, one that relates specifically to our special needs.

It would be both naïve and foolish to deny the importance of contact with the global health arena and particularly with our own occupational therapy colleagues abroad. There is currently a progressive global movement in occupational therapy that positions it far more in a health and wellness context than in one of illness and remediation. There is a growing awareness of the effects of political power and global exploitation of people and resources upon the health and wellness of oppressed communities in particular. An emphatic voice articulating and demonstrating the enabling power of occupation in both sickness and health as well as an acute awareness of the need to pay more heed to multifarious cultural needs in terms of their relationship to occupation and health is emerging [Townsend and Whiteford 2005; Kronenberg et al 2005a; Kronenberg et al 2005b; Iwama 2003, 2004, 2005 a & b; Christiansen 1999; Awaad 2003; Mocellin 1996; Wilcock 1999, 2001, 2003; Whiteford 2000; Yerxa 1995, 2000], to mention a few.

But ultimately, and firstly, we are accountable to our South African society and are mandated to serve it. Kathard⁴⁰ maintains that accountability should be the frame of reference against which our professional practice is evaluated. In order to be accountable we have to provide an appropriate service, one that takes into account the various and distinct needs of our South African peoples, be they Ethnic-African, Asian-African or Euro-African; be they rural or urban, rich or poor African. Whatever happens

³⁹ Centre for the Advancement of Interprofessional Education (CAIPE). (2001). **Towards a European approach to an enhanced education of health professions in the 21st Century**. Report of the European Interprofessional Consultation. 1999-2001.

⁴⁰ Kathard, H. (1999). **Transformation of educational and professional practice in speech-language pathology**. Proceedings of the 1999 Speech Pathology Australia National Conference: Towards 2000: Embracing change, challenge and choice. May 17-21. Sydney.

we must not allow ourselves to become an elitist profession, serving only those who can afford our services or becoming a vogue for the neurotic.

What makes South African occupational therapists different?

In reflecting on my own experience as an occupational therapist working with other occupational therapists in South Africa, and on perusing again the results of the analysis of my focus groups, the words that probably best describe South African occupational therapists are *resilience* and *adaptability*. Years of being marginalised, under-resourced and exposed to harsh and often distressing circumstances have spawned a tough, resilient and adaptable therapist who would be as capable of working in the well-resourced context of the Western world as they are in the under-resourced situations of rural South Africa.

In addition, the mix of cultures and unique languages, first and third world circumstances, now also coupled with the scourge of HIV&AIDS, exposes occupational therapists to a different type of heterogeneity and health challenge than exists anywhere else in the world. Those referred to them for therapy and support frequently present with a complex cocktail of pathophysiological, socio-economic and psychological complications that require innovative and *think-while-you-blink* solutions. Large numbers of individuals presenting with the complex peripheral neuropathies and other dreadful symptoms of HIV/AIDs are being referred to the occupational therapy departments of State hospitals because little else can be done for them.⁴¹

The following **characteristics** were identified by the focus groups when asked whether they thought South African occupational therapists had something unique to offer the rest of the world:

- Creative, innovative and lateral thinkers.
- Good at problem solving and clinical reasoning because of constant exposure to complex cases and minimal resources.

⁴¹ van der Reyden, D. & Joubert, R.W.E. HIV /AIDS in psychiatry: The moral and ethical dilemmas and issues facing occupational therapists treating persons with HIV/AIDs. In: Crouch, R. & Alers, V. (Editors).(2005).

- Flexibility and the ability to compromise and function adequately in situations with minimal resources as well as work in well resourced and high technology situations.
- Bored by too much routine and prescriptive/menu treatment protocols e.g. as set out in managed care systems.
- Hard workers.
- Independent workers.
- Are not as model-bound as their Western colleagues.
- More “hands on” and multi-skilled because of the need to improvise, e.g. having to make splints and assistive devices rather than ordering them, as well as following client’s/individual’s progress from admission to reintegration into the community. This is generally unlike Western countries where diversification of roles and division of labour results in some of these activities being spread across a range of health care professionals/workers.
- Able to adapt techniques and tests from other countries to meet needs of South Africa.
- Able to work with large numbers of people at one time and over prolonged periods of time.
- Probably more able than others elsewhere in the world to deal with issues related to persons with HIV&AIDS, due to increasing exposure to very large numbers of individuals with HIV/AIDS-related complications affecting function and productivity.

The following **challenges** facing South African occupational therapists were also identified by the focus groups:

- There appears to have been a greater move towards vocational rehabilitation and demands on OTs, particularly in private practice and private enterprise, to both assess and train individuals to return to work.
- The enormity of unemployment in South Africa offers a challenge to OT, presumably in terms of providing programmes that compensate for work loss and provide meaningful and healthy human occupation. This kind of intervention would be for people without disability who are at risk of developing or acquiring health-threatening problems such as substance abuse and depression.

- Some OTs in private practices for adults (medico-legal) appear to spend more time on assessment than actual treatment, therefore competency in assessment is crucial.
- With the implementation of more effective disability management by government, there are greater demands for OT's expertise.
- The increase in HIV&AIDS cases in public sector hospitals has created considerable challenges for OTs and a special need for therapists to learn how to deal with terminal conditions.
- The increase in recognition for the role of OT s in assessment and treatment of medico-legal cases and learning disabilities requires revision of current curricula.
- There has been an increase in acute psychiatric cases being referred to OTs in private practice.
- OTs in SA have to learn to cope under extremes of demands, ranging from working with almost non-existent resources to working with advanced technology and technical devices and high levels of resources.

Certain **deficit areas** that South African occupational therapists need to address as problematic also emerged from focus groups:

- They don't market themselves adequately and don't "brag" or try to sell their successes; they lack the confidence that their Western colleagues possess.
- They are not assertive enough in challenging others about issues they oppose or don't agree with.
- They are not producing enough research or publications, which could partly be as a result of heavy workloads and large numbers of patients, but also due to other factors such as lack of confidence in doing research.
- They have developed some good ideas and theories e.g. Creative Participation, but don't make enough effort to share these with rest of world.
- They are still too bound by Eurocentric origins and influences and need to include more information from Afrocentric origins, so essential for our survival as a profession in this continent.

The above description provides a reasonable profile of the South African occupational therapist's characteristics, challenges and deficits and as such sketches a health

professional who has the means to cope well with the newly constructed identity described in this chapter, provided the curriculum is supplemented in deficit areas.

I often joke with my students and tell them that occupational therapists need to be spiders or *isigcawu's*⁴² because as an occupational therapist one needs eight eyes and eight arms/legs to be able to think on one's feet and to hold, see and do all that sometimes becomes necessary in this profession, a profession where one should have eyes that not only look and see but which *feel* and *touch*. Hands which not only feel and touch but which *look* and *see*. And ears that *see* and *feel* what they are hearing, discerning, and listening to.

The next chapter is the final chapter and will conclude by presenting a flexible model that can be used as a guide to plan and construct new courses and directions for a curriculum, identity, ideology, etcetera. It will also conclude with a summary of relevant discussion supporting the thesis.

⁴² This is the lovely Xhosa word for a spider and has a delightful frontal click sound when pronouncing the *igc* part of the word.

CHAPTER TWELVE

Changing the Routes/Roots and Picking the Fruits!

Route map: The final chapter of this thesis will demonstrate how, apart from its obvious shortcomings, the history of the profession of occupational therapy in South Africa has contributed towards what makes South African occupational therapists unique and why this bodes well for our future. It will also present a series of scenarios using a flexible model that attempts to encapsulate where our emphasis has been in the past, where it is now and where it needs to be once we have reconstructed our identity. The chapter will also suggest ways in which occupational therapy education, its curriculum and methods of teaching need to change to build and accommodate this reconstructed identity.

Vignette # 9: Work vs. a Job

'God said we have to work, there's nowhere that he says we have to have a job.' Abdulla Ebrahim' (2006)¹.

Ripe for the plucking

There has never been another time in the history of occupational therapy in South Africa, when it has been in such an optimal position to market itself and really demonstrate its contribution along the full continuum of illness and trauma to health and wellness.

The rights of people with disabilities are protected by one of the most liberal constitutions in the world, and according to the Office of the Deputy President (INDS, 1997:v)² *"Government departments and state bodies have a responsibility to ensure that, in each line function, concrete steps are taken to ensure that people with disabilities are able to access the same fundamental rights and responsibilities as any other South African"*

An Office of the Status of Disabled Persons (OSDP) has been established in the Office of the President to monitor and ensure implementation of the Integrated National Disability Strategy (INDS). The intention of this office is for it to work parallel to, and together with, various state bodies and departments in order to promote and implement the development of a disability friendly environment. It also maintains close links with

¹ Ebrahim, Abdulla. (2006). Interview on programme "Curious Cultures" SABC 2 at 7h55 on 10 July 2006.

² **Integrated National Disability Strategy.** (November 1997). The White Paper of the Office of the Deputy President. Rustica Press. Republic of South Africa.

relevant non-governmental organisations³. The National Rehabilitation Policy (2000:1) spells out its policy of rehabilitation for all and “*is informed by the principles of development, empowerment and the social integration of persons with disabilities*”. It further states that these principles are enshrined in policy and service provision and will contribute to people with disabilities reaching their optimum potential as productive members of society⁴.

The intention of the Education White Paper 6⁵ policy framework is to ensure the removal of all barriers to learning that the inequities of the past produced. These were evident in the imbalances of decades of segregation and under-resourced education which occurred between the special schools that catered exclusively for white disabled learners and those for black disabled learners, and where the destruction of apartheid remains most evident. The result of this policy was that only a small percentage of learners were accommodated in special schools and thus a large percentage of learners with disabilities was unaccounted for. [*My own experience in the community service learning projects for disadvantaged children with disabilities that I have been involved in with students, in a semi rural area, is that a large percentage of these children are kept at home and never attend school. In the case of those who are sent to school, they either adapt and cope fairly well or, more commonly, are teased and ostracized by peers, or are unable to cope because their teachers do not have the necessary training and skills to deal with their problems, or they are marginalized within the classroom setting and thus their learning capacity is further compromised.*]

This White Paper 6 also sets the framework for the transformation of education to provide educational opportunities, more particularly for those learners who experienced barriers to learning and development and who have dropped out of, or are excluded from, learning because of the inability of the education and training system to accommodate the diversity of their learning needs⁶. This is another “*post-apartheid landmark policy paper that cuts our ties with the past and recognizes the vital*

³ Philpott, S. (2006). **Policies and legislation relating to disabled people in South Africa.** Notes compiled for the community orientation programme for Audiology, Occupational Therapy and Speech and Language Therapy Students at the University of KwaZulu Natal. Durban.

⁴ The National Rehabilitation Policy (November 2000), Department of Health, Pretoria, South Africa.

⁵ Education White Paper 6 (2001): Special Needs Education. **Building an inclusive education and training system.** Department of Education, July 2001, Pretoria.

⁶ Ibid

contribution that our people with disabilities are making and must continue to make, as part of and not isolated from the flowering of our nation” (Asmal 2001: 3)⁷.

Social development policies have also been created or adapted to accommodate people with disabilities. Prior to the integrated national disability strategy, the approach of the Department of Social Development was one based upon the medical/welfare model of disability, which makes the assumption that people with disabilities are unable to care for themselves and therefore need to be cared for and helped⁸. A major shift away from this is articulated in the White Paper for Social Welfare (RSA 1997:5), which stipulates a system of welfare that *“facilitates the development of human capacity and self reliance within a caring and enabling socio economic environment”*.⁹ This has made it far easier for people with disabilities to access disability grants¹⁰.

There are eight Acts and two codes related to labour and employment that were passed between 1993 and 2000, which together have had considerable impact on the workplace and employment practices. They also have particular relevance to people with disabilities because they provide for both an enabling and supportive work environment and create less discrimination and greater placement opportunities for those with disabilities.¹¹

While some of these have specific references to people with disabilities, others affect all employees and set down legislation and codes of good practice¹² that assist employers and employees in ensuring equity¹³, safety in the work place¹⁴, absence of

⁷ Asmal, K.(2001). **Introduction by the Minister of Education to the White Paper 6:** Special needs education: Building and inclusive education and training. July 2001. Department of Education. Pretoria.

⁸ Philpott, S (2006)

⁹ The White Paper for Social Welfare(RSA 1997). Government Printers, Bosman Street, Pretoria 0001.

¹⁰ Philpott, S (2006)

¹¹ Silver, R. & Koopman, B. (2000). **Successfully Employing People with Disabilities: Business for goods focused guide to employment equity.** Business for Good, Seapoint. Cape.

¹² The Labour Relations Act, 1995 and The Basic Conditions of Employment Act, 1997

¹³ The Promotion of Equality and Prevention of Unfair Discrimination Act, 2000

¹⁴ The Occupational Health and Safety Act, 1995.

discriminatory practices¹⁵ and installation of rights-based practices¹⁶, skills development¹⁷ and greater access to employment for disabled¹⁸.

There are also justice policies and legislation that contribute positively towards the situation of people with disabilities, and towards creating an environment that supports the prevention of disabilities and ill health. In the strategic overview of the Department of Justice's National Treasury report,¹⁹ there is support for a legal framework that particularly promotes access of vulnerable groups to justice and this includes people with disabilities²⁰. In addition, there is a whole range of Bills and laws in place to protect vulnerable groups and prevent illness and disability through neglect and abuse²¹.

This political and legislative framework and ethos of support for, and inclusiveness of, people with disabilities in South Africa, while most admirable, still requires considerable development of human resources and infrastructure to ensure its correct implementation and sustainability. It thus necessitates that advocates such as occupational therapists ensure that it becomes entrenched into all aspects of our society and, where it is not working, that change and additional legislation is put in place. Occupational therapists working in South Africa thus need to have a good knowledge of appropriate legislation and policy to ensure that they are able to monitor its implementation and confront situations in which it is not implemented.

This very liberal and disabled-friendly legislation also opens doors for occupational therapists by virtue of their expertise in human occupation, and the accompanying ability to advise employers on adapting the workplace to make it more accessible and accommodating for people with disabilities. In the schooling system, occupational therapists can advise teachers about seating and positioning of disabled children and how to adapt classrooms and teaching in order to provide an optimal learning situation for such children. They can advise on how to adjust and adapt the presentation of the syllabus in order to accommodate learners with different abilities and styles.

¹⁵ The Promotion of Unfair Discriminatory Act, 2000.

¹⁶ The Basic Conditions of Employment Act, 1997.

¹⁷ The Skills Development Levies Acts of 1998 and 1999.

¹⁸ The Promotion of Equality and Prevention of Unfair Discrimination Act, 2000.

¹⁹ National Treasury, 2003, Estimates of National Expenditure

²⁰ Philpott, S (2006)

²¹ Ibid

There is still a high level of poverty in this country; unemployment is approximately 54% and of those who are employed, 70% earn less than R1000 per month²². This situation must result in occupational deprivation for those concerned and often leads to crime and substance abuse. Occupational therapists' involvement in the planning of programmes to generate income and to occupy the unemployed in meaningful and enjoyable leisure and sport activities would contribute to the alleviation of problems brought about by unemployment.

Changing the Routes

It is important to state here that the medical model, by virtue of the changes in health legislation that have occurred in South Africa since 1994, is also transforming to accommodate itself within the new policy and legislative framework. It would be unfair to say that it has remained embalmed in its old and rigid womb. But it is also not the purpose of this thesis to analyse precisely what this transformation has been and how it has occurred.

In a description of the 'new' South African community psychology, Swartz and Gibson²³ maintain that it differs from the 'old' in almost every aspect. For example, professionalism is rejected in favour of community participation; elitist academic knowledge in favour of lay understanding, and the consulting room in favour of community based interventions. The 'new', they maintain, is about trying out new roles, breaking old rules and discovering things that are impossible to discover in the consulting room.

Much of what Swartz and Gibson refer to here is applicable to occupational therapy as well. If we are to reconstruct our identity to more appropriately meet the needs of the diverse communities we serve, then we have to do similar things. This does not mean a total baby and bathwater chuck-out: rather it means a shift in emphasis and situation and a taking on of new roles. It means a change in attitude and a new becoming: a becoming that is proud and assertive yet gentle and sensitive, a becoming that can move just as

²²Vavi, Z. Labour and the tripartite alliance. In: Bowes, B. Lundy, G. & Pennington, S.(Editors) (2004).

²³Swartz, L. & Gibson, K. The 'old' versus the 'new' in South African community psychology: the quest for appropriate change. In: Seedat, M. Duncan, N. & Lazarus, S. (Editors). (2001).

easily along tarred roads and in white-coated clinics as it can on dirt roads amidst brown-earthed communities.

If we return to the characteristics identified in the focus groups as being those that made South African Occupational Therapists unique²⁴, it is evident that the very characteristics required in this process of becoming our restructured identity have already started to emerge, sculpted by the very historical and contextual circumstances that surrounded the development of the profession. Circumstances that, by virtue of their negativity contributed to a robustness and resilience that bodes well for the future of occupational therapy in this country.

Ironically, the report of the European Interprofessional Consultation²⁵ (1999-2001:5) has, as its key proposition for universities of the 21st century, that they should “*accept responsibility to ensure that graduates are able to adapt to change and corporately to participate in the management of change*”. The irony lies in the fact that, having been the victims of a European Higher Education ideology for the years preceding apartheid, an ideology which still partially permeates Higher Education, and having been the victims of marginalization and oppression by paternalistic forces as well as being centered in the dislocative period between the birth and death of apartheid and the birth of a new Africanism, occupational therapy has indeed learnt both to adapt to change and to participate in its management.

I am now going to try to illustrate how the facts and circumstances previously described in our history affected the changing identity of occupational therapy and consequently also its curriculum over the past years. This will be done by using a model that can be adjusted, flexed and tweaked to demonstrate these changes. The model can also be adjusted, flexed and tweaked to portray desired future scenarios or varied scenarios that may be designed to meet specific situations, contexts and circumstances.

²⁴ Chapter 11 page 253-255

²⁵ Centre for the Advancement of Interprofessional Education (CAIPE). (2001). **Towards a European approach to an enhanced education of health professions in the 21st Century.** Report of the European Interprofessional Consultation. 1999-2001.

The Focus And Emphasis model of recovery (FAE Model): Definition and description

The FAE model may be used to depict the changing dynamics between two opposing ideologies, ideas, categories of information or forces in which one is becoming less dominant than the other. It is also used to illustrate how two opposing forces may be inextricably linked, sharing alternating periods of dominance and recession perhaps culminating in the even eventual disappearance of one or the other, during this period of linkage. As such it allows one to plot changing and desirable scenarios under each phase of dominance, recessiveness and/or disappearance of such ideologies, categories, forces, etcetera.

In this particular chapter, it will be applied to the process of an individual's journey from illness/trauma to recovery and final integration back into the community, and as such, this model is based upon two basic assumptions:

The first is that after any major insult or injury to one's psyche (mind) or soma (body), through whatever reason, one's physical and/or mental health is either severely compromised or becomes extremely vulnerable and this in turn affects one's occupational ability which affects one's independence and quality of life. At such moments, one will usually require medical intervention and care as an interim measure to assist one in overcoming various patho-physiological sequelae that may or may not be life threatening.

The second is that, generally, humans are inherently capable, aspire to success and have the power to make choices about themselves and their future²⁶. As such they are capable of taking control of their lives completely or to a greater or lesser extent, depending on the seriousness and/or permanency of the sequelae of the insult or injury referred to above. Even in the presence of extreme physical impairment that renders one totally dependent on others, one is still in a position to control how others perform acts for one, such as bathing or feeding.

²⁶ Covey, S.R. (2004). **The 8th Habit: from effectiveness to greatness**. Simon & Schuster, London.

This model is based upon two opposing triangles situated on the same axis but one depicts a more becoming less shift in focus and emphasis as follows:

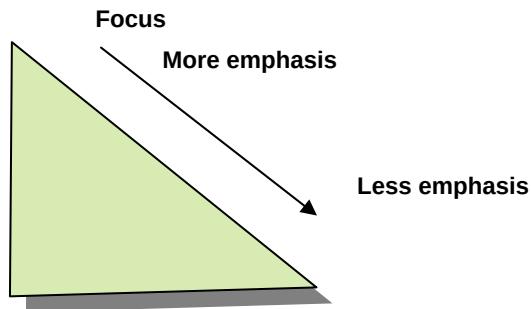


Diagram 1: More becomes less

The other triangle depicts a less becoming more shift of emphasis as follows:

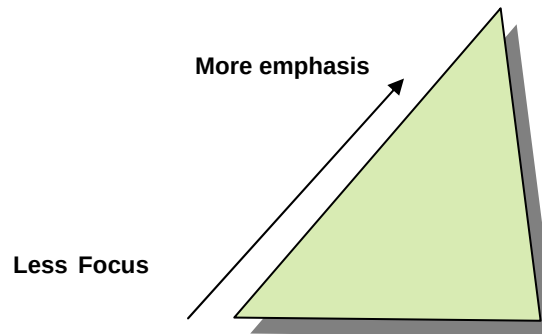


Diagram 2: Less becomes more

Thus if one puts these two triangles together on the same axis they look like this:

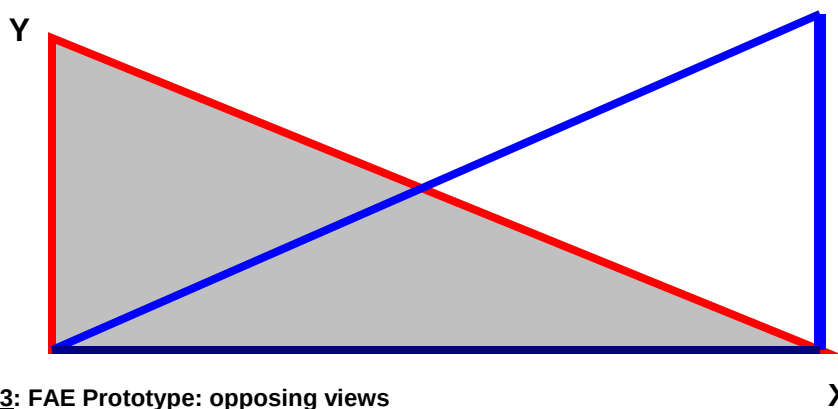


Diagram 3: FAE Prototype: opposing views

Each triangle is named according to which particular ideology, aspect of intervention/treatment, focus or role one wishes to de-emphasise or (re) emphasise. The **Y-axis** represents the depth or magnitude dimension and the **X** represents the time

dimension. In this chapter this model will be used to illustrate a number of ways in which the model can be manipulated, but particularly to illustrate and summarise the key theories being explored in this thesis, and how they have influenced the relationship between the occupational therapist and those s/he serves. It will also be used to suggest how a restructured identity of occupational therapy can be depicted using this model.

Thus, in this context, the red triangle in diagram 3 above will represent the medical model (illness orientation) and the blue triangle will represent the social/developmental model (wellness orientation). Particular categories of comment can be columnised under the extreme left, middle (where the two hypotenuse lines bisect one another) and right of the diagram as illustrated in diagram 4 below, to verbally describe the changing focus.

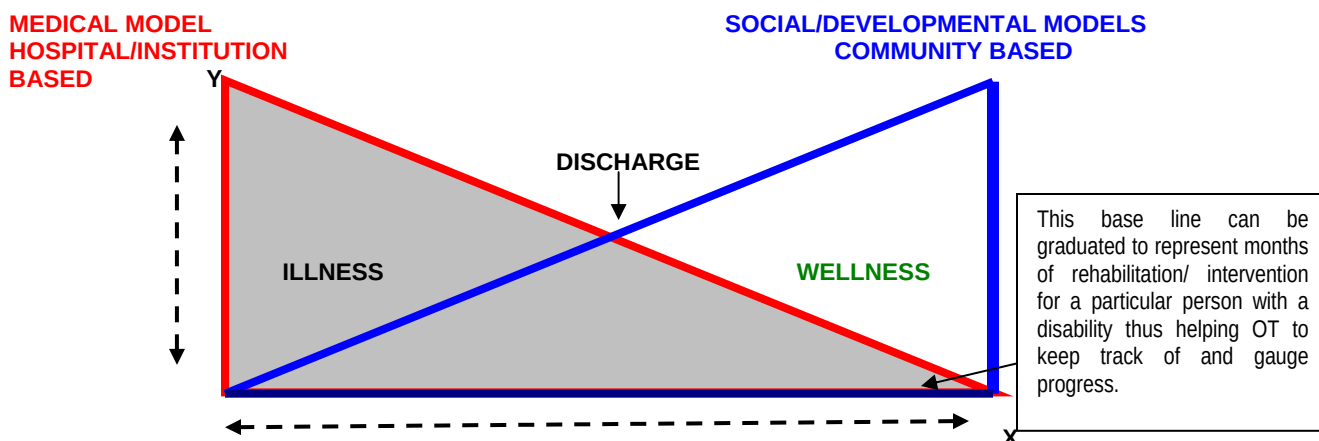
However, it is suggested that if one is using the model for other scenarios and one wishes to name each triangle, the left hand triangle could be referred to as the MBL (more becomes less) triangle and the right hand triangle as the LBM (less becomes more) triangle.

Using the FAE Model to summarise the key points of this thesis

The following representation of the model is a neutrally balanced prototype that is used in this context more as an illustrative scenario than a typical or ideal one, and will be used as the basis upon which to discuss the key points of this thesis. It forms the starting point from which the model can be manipulated to depict or fulfill various needs or desired scenarios. The model can thus broadly be used to do the following:

- Depict ideological focal shifts.
- Depict historical influences.
- Depict shifts in focus of occupational therapy intervention.
- Isolate single aspects within opposing/differing ideologies or interventions and provide a more microscopic perspective on them in terms of how they interact upon each other.
- Position key components of the ideology or intervention in their particular context within the model so as to be able to locate oneself precisely within that particular form of the model.

- Position one's point of focus for intervention when planning treatment or other interventions to facilitate recovery.
- From an educational perspective, it is possible to tweak, flex and manipulate the model to depict one's own particular ideal in terms of where one believes the focus of training should lie.
- To plot the progress of recovery of an individual who has been disabled, from the moment of admission to hospital to that of their reintegration back into society. (See diagram 4: text box right). This allows therapists and students to determine whether they are on track with their rehabilitation and intervention programmes.



ROLE of OT:	Therapist Expert Mostly Under control of doctor	Facilitator/ Collaborator Person/client centered	Partner Mediator/Advocate Consultant Programme manager Change agent Resource person
ROLE OF: CONSUMER	'Patient' and passive recipient Victim	Client/person	Expert on disability Partner, agent Resource person
AIMS OF INTERVENTION:	Remedial/curative	Maintenance/ Rehabilitative	Integrative/ promotive maintenance
	Preventive		
	Palliative		
	Assessment		
METHODS OF INTERVENTION:	'Treatment' curative Remedial activities e.g. crafts/techniques to improve performance Components, Specialised techniques	Training Activities to improve Performance Areas e.g. self care, domestic. School readiness Social skills	Integration Social skills Community survival Vocational/work training Occupational wellness Programmes Medico-legal/insurance
TYPE OF CONTACT:	One on one Small Group	Caregivers	Individuals/groups/ Communities Stakeholders
RESEARCH FOCUS	Quantitative/ Positivist		Qualitative Ethnographical/ Critical/phenomenological Emancipatory. etc

Diagram 4: The Prototype FAE Model of Recovery

This diagram represents a very neutral balance of two particular ideological emphases within the continuum of recovery from admission to hospital to integration back into the community. If one thus views the columnised comments below the triangles, in diagram 4 above, in relation to these red and blue triangles, then the description given on the left (red triangle) implies that this is where the emphasis is placed at the onset of disability (i.e. medical model/positivist and illness orientation) and as the hypotenuse line progresses downwards to the right, so that particular emphasis diminishes.

The reverse of this occurs with the blue triangle so that those aspects specified in the left hand column are minimally emphasised in the blue triangle (social/developmental and wellness orientation), but as the hypotenuse line rises upwards so those aspects specified in the right hand column become the focal point of emphasis. In this particular form of the diagram, the implication is that neither one nor the other orientation is ever completely absent, thus even at the strongest point of the medical model orientation, within it there are still aspects of the social/developmental model orientation that are of significance and relevance at that stage of acuteness or recovery, and vice versa. The overlapping of the two triangles should therefore be seen as an integrative component in which various aspects of integration of one or other ideological stance are less or more at various stages of the process along the time frame of axis X.

Where the two hypotenuse lines bisect, there is a more or less equitable orientation to both the medical and social models, and this can be used as an indicator of readiness for discharge for someone who has been hospitalized or institutionalised. It can also be used as an indicator of the turning point at which the individual begins to take complete control over his/her life and recovery.

In addition to this, although a particular aspect or function may be emphasised at a specific point on the model, for example the role as *therapist* in the early stages of the recovery process does not mean that there is not a people/client-centered orientation during this phase, but that the emphasis is on being therapist by virtue of the acuteness of the stage of recovery and on the *treatment/curative* focus of intervention when the individual under care may be so seriously ill or traumatized that it is essential that others take control for them until they are capable of doing so themselves.

The bi-directional broken line under the X-axis suggests that it is possible for the recovery progress of an individual to move in a bi-directional manner, improving and/or regressing and/or fluctuating along this line. The bi-directional broken line next to the Y-axis suggests that the depth or degree of emphasis of a particular variable such as, in this case, medical or social model, may also vary. Thus, for example, if an individual has a life threatening traumatic event (head injury) that requires placement in an intensive care unit, as opposed to someone who is admitted to hospital after a less traumatic event (hand injury), the degree of emphasis on the one or other variable may be greater or lesser and, depending on the progress towards recovery, may also be bi-directional if there are episodes of improvement and/or exacerbation of the condition.

Having explained and illustrated how the model works, I am going to show how one can adjust, flex and tweak it to demonstrate variations on this theme. For example, one can extract any single aspect from this model and apply the focus and emphasis to it to plot out progress from one extreme to the other. Thus if, for example, we take the continuum of dependence to independence, it would be represented as follows:

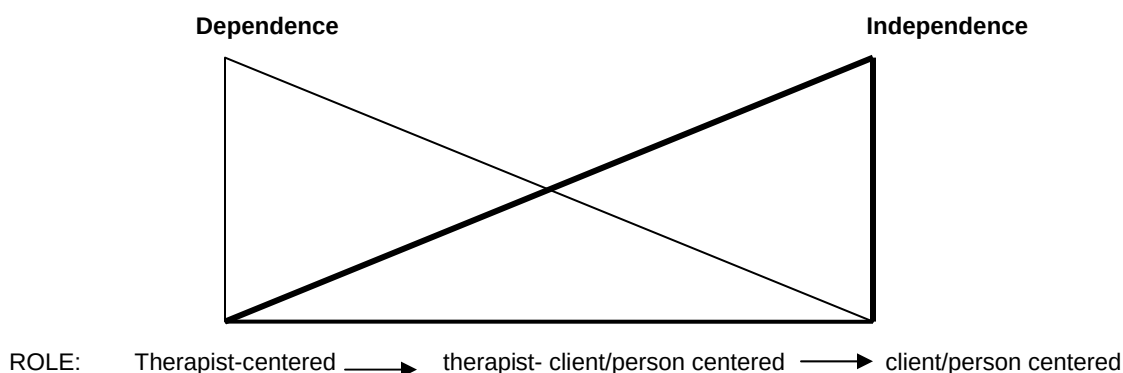


Diagram 5: Emphasis on the particular roles of therapist and client/disabled person during process of recovery of independence.

Thus, in this diagram, the single aspect of dependency versus independency is demonstrated showing that in the acute, admission to hospital stage of recovery the emphasis within the intervention process is still mostly therapist directed (this does not mean that there is no *patient* direction, simply that it is minimal). As the individual commences regaining independence, so the roles equalize and then the client/person starts to take greater responsibility for his/her recovery. And finally, in the integration phase of recovery, the therapist's role has decreased and the client/person's role has

increased to a stage where they are taking the majority of, or complete responsibility for their own independence.

The following example, diagram 6, will illustrate how the model can be used to depict the history of the development of occupational therapy in South Africa as portrayed in this thesis. This will be followed by a discussion explaining how and why the historical circumstances and situation resulted in this particular rendition of the model, which will highlight where the flaws lie and thus where they should be changed. The model can then be tweaked and manipulated to bring into being a more realistic and appropriate interpretation of how the reconstructed South African occupational therapy identity and curricula should be represented today, see diagram 7.

Medical Model Institution-based

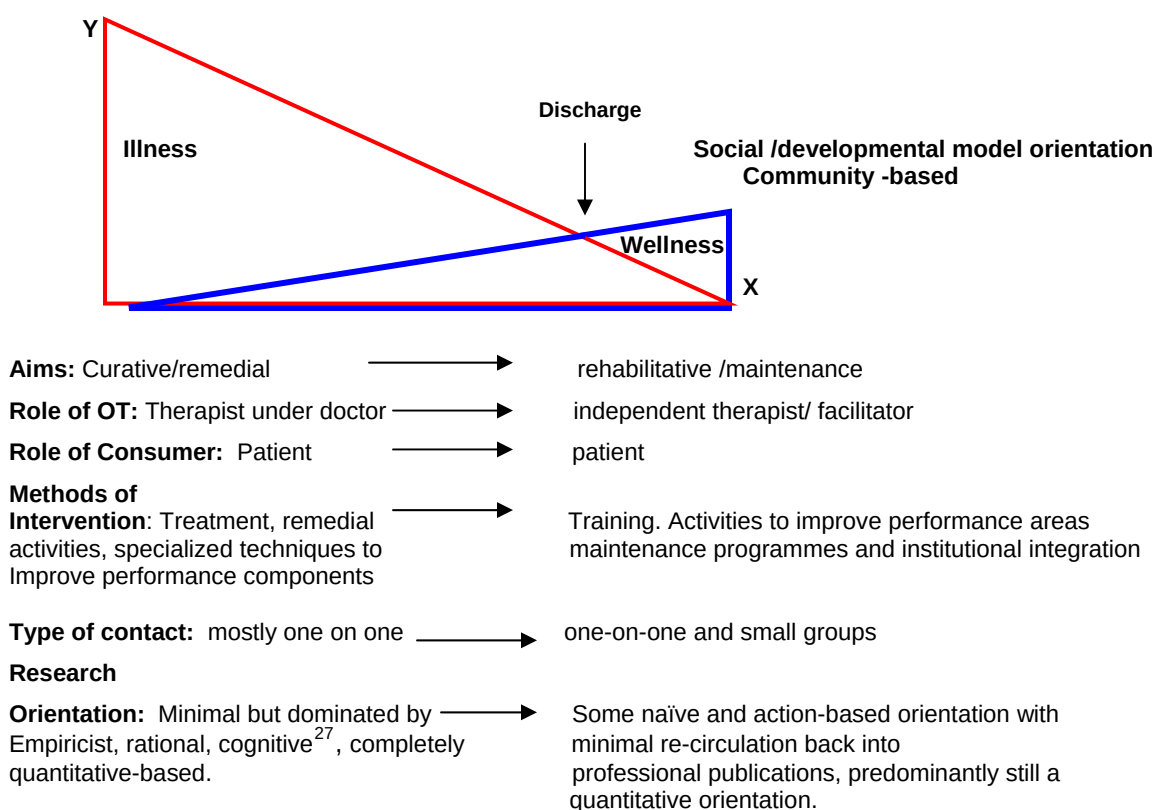


Diagram 6: The FAE model illustrating how historical influences impacted upon the process of recovery and the occupational therapy orientation.

²⁷ Denzin, N (1994) The Art and Politics of Interpretation: 511.

If one compares diagram 6 with the original prototype FAE model of recovery (diagram 4) on page 259 there are several observations that need to be clarified.

Firstly it is obvious that the third (integration phase) of recovery is not represented in this diagram. The reason for this is evident in the preceding historical review i.e. because of the dominant forces and circumstances prevailing at the time, therapists were almost exclusively institution based. Hence, although some community-based, integrative facilitation did occur, it was minimal and mostly of a *remote control* type whereby therapists consulted telephonically with relevant stakeholders and role players such as family and employers. A few cursory visits could, on rare occasions, be made to the home and employment of the person being integrated back into his/her community, but for the most part, guidance and assistance from within the institution was conveyed to the community setting either through written report or telephonically. In this way the discharge and integration phases of recovery became conflated and their clear and essential distinction was never properly actualized within the occupational therapy curriculum of those days.

This situation was exacerbated by the fact that many South Africans who were referred to occupational therapy lived in rural areas far from the hospitals where they were admitted, and because there was no community-based resource infrastructure, it was impossible for occupational therapists to do home or work visits.

Secondly it is obvious from the difference in sizes of the two triangles where the majority of emphasis and control of process lay at the time. The social/developmental – wellness orientation although present in the mindset of occupational therapists was rarely practised because of the circumstances making it virtually impossible to do so.

Thirdly, it is also apparent from this diagram that the roles of partner, mediator, advocate, agent and programme manager that occupational therapists need to assume, are absent at this phase of occupational therapy's development. The forces and circumstances prevailing at the time, made it virtually impossible for occupational therapists to develop beyond the confines of the hospital, institution and 'home'²⁸. Thus a confined, misinformed and narrow-minded worldview was predominant. Huge gaps in

²⁸ Home in this instance refers to residential homes for elderly and orphaned or physically disabled.

the profession's knowledge base existed regarding indigenous knowledge and insight into the relationship between occupation and health of the diverse cultures of South Africans other than white, creating a one-sided and inequitable knowledge base that did not serve the majority of South Africans at the time. Lack of adequate input by the disabled as experts further compromised the situation.

In addition, an essential emphasis on developing in occupational therapists the knowledge, skills and attitudes necessary to orientate them towards integrating people with disabilities back into society and preserving the wellness of those they served was largely absent, or theoretically and Eurocentrically biased.

Fourthly: the consumer of occupational therapy services at this stage of our development never really became '*person*' - they were always a '*patient*' because we rarely if ever saw them outside of the confines of the hospital/institutional setting and thus the absolutely crucial person (client)-centered approach of empowerment and respect for the disabled person as expert hardly existed. This created an abnormal distribution of power of therapist over '*patient*' as can be easily demonstrated in the FAE diagram 7 below:



Diagram 7: FAE representation of the focus of the seat of power between OT: patient in the early development of occupational therapy

Fifthly, the point of transection between the two hypotenuse lines represents the point of transition from being controlled, as opposed to taking control, of one's own life. Using this model, it is possible to determine/estimate at what stage the '*patient*' becomes '*person*' and controller of his her/his own life. Compared to the prototype diagram (4) of the model on page 259, this transition takes place much later, thus increasing the potential for the '*patient*' to be much more easily socialized into her/his role as patient

and recipient of help and assistance, rather than taking responsibility for and control of her/his recovery. Obviously the sooner this transition takes place, the better.

Finally, and perhaps most importantly, the focus was on illness and cure/remediation rather than on wellness and integration. The consequence of this for the occupational therapy curriculum was that the essential component of integration was always mostly theorized and rarely if ever practised. Thus occupational therapy trainees had little, if any, exposure to the implementation of this theory and were therefore unable to actualize its essential fact and features in experiential practice. The process of living out the theory in a service-learning context was never fully made possible and thus could never fully develop.

This situation entrenched a leaning towards the illness/curative attitude to recovery rather than the wellness and integrative one. It is perhaps one of the most important flaws still evident in our current practice that, while we theoretically place high focus on integration, it is not adequately practically implemented. All too often we still see individuals with disabilities who have supposedly had intensive rehabilitation, but are nonetheless poorly integrated and unhappy people.

Another important development in this focus on wellness discussed in the previous chapter is that of the role of occupational therapists in prevention of illness which may occur through various forms of occupational disruption²⁹ such as occupational deprivation, occupational overload³⁰, and/or occupational apartheid and injustice. In these instances the individual may not yet be in need of medical intervention but may simply require expert advice on lifestyle analysis and restructuring to bring about greater balance in order to maintain wellness. Or the occupational therapist may make recommendation to appropriate government structures regarding the implementation of, for example, recreational and skills development programmes that may be used to counteract such situations for individuals, groups or communities at risk.

²⁹ Occupational Disruption is used here to describe a series of situations and contexts which impact upon the individual's ability to either freely participate in occupations of their own choice or where such participation is out of synchronization with normal daily life expectations. Such situations normally become threatening to the individual's wellness. e.g. individuals who are institutionalized, incarceration.

³⁰ Occupational Overload is a neologism coined to describe the trend towards frenetic lifestyles that modern, mostly urban, people live, in which their lives are so overloaded or unbalanced with various occupations or unbalanced with one form of occupation superseding others, that it becomes threatening to their health and may result in burnout and other conditions that affect wellness.

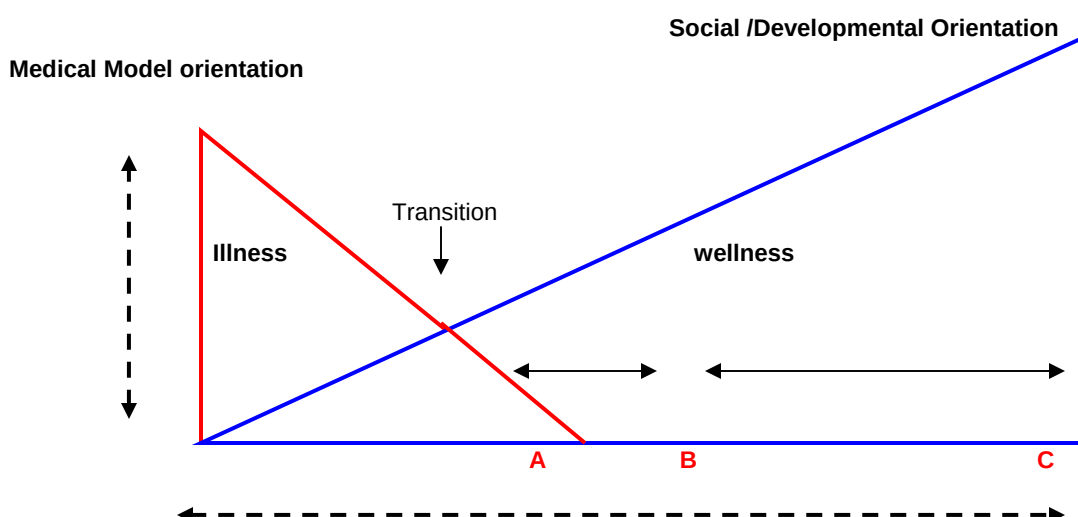
Different routes and roots

Finally, before turning to the concluding pages of this chapter and thesis, I would like to use the model to illustrate a more appropriate and realistic representation of how I believe occupational therapy in South Africa should appear today. Obviously this model represents our role as it relates to the broader South African population and would therefore not necessarily fit the South African occupational therapist in an up-market private practice, for example.

But I believe that the following model does represent ideological principles that would be appropriate in any occupational therapy setting. Aspects such as, for example, the people-centeredness of our approach, the orientation towards wellness rather than illness, our roles as advocates and agents for change and as facilitators, mediators and collaborators should be applicable to any area of practice, be it in impoverished communities or amongst the rich and wealthy. Thus, for example, a child with learning disabilities would fall within the B to C part of this model and emphasis in intervention would fall within those areas highlighted for this aspect of the model

The model below (diagram 8) is suggested as a broad-brush representation of exactly where and how occupational therapy should be situating itself within the illness and wellness continuum in South Africa today. It has tried to reflect an even balance of past historical influences and present needs and influences within the South African context. As such it also reflects the ideological imperatives that are manifest within the South African Government's bill of rights, constitution, and legislative framework.

I am sure few would argue with me when I suggest that by far the greatest proportion of our time should be spent in the area of achieving, maintaining and promoting wellness both for those who have impairments and for those without, but who are at risk of developing ill health through occupational disruption. The 'ideal' model represented in diagram 8 above, requires further debate and discussion within the profession to refine and expand upon it.



Role of OT: Therapist	→	Facilitator/Collaborator	→	Partner, mediator, advocate, agent, consultant, programme manager, resource person.
Role of Consumer: Patient Passive recipient	→	Person/client/individual Expert on disability	→	Partner, consultant, resource Participatory, active agent in integration process
Aims of engagement: Curative /remedial assessment	→	Rehabilitation maintenance promotion	→	Integrative, capacity building, screening, participatory rural/urban appraisals, maintenance promotion
prevention palliation	→		→	
Methods of Intervention: Treatment Remedial activities Emphasis on Performance Comp-onents. Use of special techniques e.g. splinting NDT etc	→	Training and activities to improve performance areas, social skills training, Community survival, School readiness programmes Caregiver training, Vocational Assessment and training	→	Integration, community survival, life skills, income generation, work placement, medico-legal/ insurance assessment. HPROP ³¹
Type of Contact: one on one small group	→	one on one and small group caregivers, givers, stakeholders	→	one on one, small group, care large group communities
Research Focus largely quantitative	→	quantitative and qualitative	→	largely qualitative, ethnographic action research

A-B = point at which institutionalization may occur for severely impaired individuals who have no family to care for them or who require constant specialized care.

B-C = the period of development and recovery wherein there is no medical pathology and thus no need for extraordinary medical intervention.

Diagram 8: A broad representation of the ideal³²

³¹ HPROP: Health promotional occupation programmes, for example income generation projects, recreational programmes for youth, developmental programmes for babies at risk etcetera.

Certainly occupational therapists have a role working within predominantly medically oriented situations such as hospitals and clinics that admit physically and mentally sick and impaired persons. Apart from assisting the physically and/or mentally impaired person with the remediation of physical and psychological performance components that may have been affected by illness or trauma, they have a particularly important catalytic role in re-establishing a sense of hope in one's future and a fragile confidence in oneself, for those in the early and vulnerable stages of their recovery.

Occupational therapists also have an important role in the medium and long-term institutional settings³³ where individuals with serious physical and mental impairment need special care. Examples of these would be psychiatric institutions, homes for the elderly and homes for orphaned children. These institutions are particularly open to abuse of power by health professionals and caregivers over those subjected to living part or the rest of their lives within them. Thus, although philanthropic ideals are much more entrenched within the policies, visions and mission statements of such institutions today, we should not forget Foucault's concerns regarding what he referred to as the asylum. Often the essence of these policies, visions and missions remains somewhat mythical in that they are rarely, if ever, actualised in their translation into reality. Foucault maintained that beneath these myths there is an operation, or rather a series of operations, which silently organises the world of the asylum and the methods of cure and at the same time "*organizes the concrete experience of madness: 142*"³⁴ or that of physical impairment. Occupational therapists working in such establishment should not only provide occupational programmes that alleviate the occupational disruption of those living permanently or temporarily in these institutions, but should be agents that work against any form of system or organization that deliberately oppresses and undermines their inherent capacity and ability to make decisions and choices.

With the exception of some individuals, for example, those in long-term coma or suffering from severe psychotic problems who may require constant medical care, most individuals falling within the A and B part of the X axis above may require occasional and

³² I am eternally grateful to my academic colleagues, Dain van der Reyden, Julie Lingah, Kathy Holland, Mandla Phehlukwayo, Anisha Ramlaul and Angel Hargreaves, all of whom gave me feedback on the prototype model, diagram 4 on page 259 which has contributed to the construction of this final representation of the 'ideal'.

³³ Situated between points A and B on the above diagram

³⁴ Foucault, M. The birth of the asylum. In: Rabinow, Paul. (Editor) (1991).

minimal medical intervention (A), but for the most part they remain within the wellness and social/developmental model orientation (B).

Thus the authoritarian and disciplinary approach and role of health professionals (including occupational therapists) which is associated with the medical model should not be allowed to prevail and should be replaced rather by a facilitatory, agential, collaborative and mediatory role.

In a discussion on the individual's autonomy in a hospital or institutional setting, van der Reyden³⁵ maintains that the changing approach to health care in South Africa reflects a greater respect for the autonomy of those who use the service. This has resulted, she says, because of a greater awareness and conscientising of individuals to their constitutional and health rights, a greater degree of questioning of health care largely due to improved access to information on health care and greater respectability being given to alternative therapies, including traditional medicine. Moreover, recent legislation such as the National Health Act 61 of 2003³⁶ and the Mental Health Care Act 17 of 2002³⁷ make it a legal essential for practitioners to unfailingly and unconditionally uphold the right of individuals under care to participate actively in the planning of intervention, to have their ability to exercise informed consent and to make decisions about their own health care needs respected. This, van der Reyden says, challenges the old paternalistic, typical medical model practice and should fundamentally lead to change in the attitude and behaviour of health care practitioners. The role of the occupational therapist in serving those confined to institutions is represented in diagram 8, page 274, as the point between A and B on the X-axis of the two triangles.

By far the most important role of the occupational therapist in South Africa today should be community-based, out there in the world of wellness (occurs within the B and C portion of the social/developmental-wellness ideology). It is a role which partners with those who can benefit from our particular expertise in the field of human occupation; one that mediates for those oppressed and marginalized because they are different; one that facilitates integration of physically and mentally impaired persons back into their

³⁵ van der Reyden, D.(2006). **A commentary on South African legislation governing ethics and practice in occupational therapy in South Africa.** Mini Dissertation in partial fulfilment of the requirements for the LLM (Medical Law) degree, University of KwaZulu-Natal. Durban.

³⁶ The National Health Act 61 of 2003.

³⁷ The Mental Health Care Act 17 of 2002.

communities. A role which advocates for the rights and supportive policies of any particular marginalized and oppressed persons, groups or communities and acts as an agent for change. It is also a role of consultant, as one who has a deep and intimate understanding of the healing powers and empowering capacity that is inherent in occupation. It is a role that can manage programmes that are designed to build the occupational capacity and skills of persons who have been exposed to occupational disruption or to use the healing powers of these programmes to restore health and wellness to such individuals.

The ideal model portrays the principle of only minimal and essential exposure to medical intervention with the aim of rapid discharge and transition into the integrative phase of recovery. Once this occurs, with some exceptions such as chronically mentally ill persons, the physically or mentally impaired person is no longer 'sick' and is only in need of occasional medical care as would be those without impairment. It is thus more important at this phase to concentrate on their rapid and fluid integration back into society and to ensure the maintenance of their wellness through procuring their rights and ability to participate actively and equally in society.

Obviously the emphasis of this thesis is on occupational therapy's development in South Africa, with particular reference to the impact of the traditional medical model ideology upon this development. It should be noted, however, that the changing face of health care in South Africa, backed by its constitution and legislation, has impacted upon all health professions and health-care delivery and thus the old ideological dogma of the medical model is being softened and changed by this and other global trends to become more community-based and less controlling.

Although the model and practice advocated here might appear to be biased towards people and communities that are socially and economically disadvantaged, it is clear that all people with disabilities are marginalized, regardless of whether they are from advantaged or disadvantaged communities. Certainly those people with disabilities who are also living in poverty are far more disadvantaged. Research by the *Knowledge and*

Research programme³⁸ indicates that people living with poverty are often more frequently exposed to conditions that cause disability, and that those with disability are more likely to struggle with finding employment and the constraints of limited resources. However, the fact remains that people with disabilities are disadvantaged, marginalized and often oppressed, their socio-economic status notwithstanding.

What is important is that both disadvantaged and advantaged people with disabilities would require the same interventions based on the same principles suggested in the 'ideal' model (diagram 8). The only major differences would be that the recovery process would take longer for those who are socio-economically disadvantaged and that necessary resources would be less available and more difficult to secure, thus diminishing the chances of complete recovery.

A significant difference for the advantaged group would be the fact that they are more likely to seek out and pay for their wellness. Thus, for example, a parent of a child who has no apparent learning problem may send the child for occupational therapy in a private practice, simply to fine-tune the child's school readiness skills and abilities in order to make him *more* ready for school. Another example might be a CEO of a company who feels he is starting to burn out and may go to an occupational therapist for lifestyle rebalancing³⁹ and stress management.

A recent survey in the United States suggests that more than half the American population will develop a mental disorder in their lives⁴⁰. This constitutes millions of people whose occupational roles will be compromised by such illness. And although changes in societies and differences in cultures over time make it difficult to compare prevalence levels of mental illness globally, it is probable that this trend may be extrapolated to other countries to a lesser or greater extent. It is quite likely that a large

³⁸ Albert, B. (2005). **Lessons from the disability knowledge and research (KaR) programme.** Overseas Development Group. University of East Anglia.

<http://www.disabilitykar.net.learningpublications.contents.hotmail>

³⁹ Lifestyle rebalancing is a neologism that refers to the assessment of one's existing lifestyle to determine whether it is healthily balanced and to make the necessary adjustments to it, for example inclusion of recreational time, to rebalance it into a healthier lifestyle if the time they are exposed to work is too excessive.

⁴⁰ Carey, B. (2005). **Moods, Madness and Mania; Mere Eccentricity, True Mental Illness or Something in Between?** The New York Times, Articles selected for the Sunday Times, Sunday Times, 3 July 2005.

proportion of these mental disorders would be preventable with adequate occupational intervention strategies in place to do so.

In 1998 a World Federation of Occupational Therapists (WFOT) survey⁴¹ revealed that the eight most common health problems⁴² seen for intervention by occupational therapists were, in rank order: people who had had a stroke (cerebro-vascular accident and hemiplegia), people suffering from schizophrenia, children with developmental delays, children with cerebral palsy, people with neuromuscular disorders, children with learning disabilities, people with Alzheimer's disease and people with bone fractures. What is notable about this list is that it contains a mix of conditions on both sides of the illness and wellness continuum. For example the stroke, schizophrenia, cerebral palsy, neuromuscular disorders and fractures are situated more towards the illness part of the continuum whilst the Alzheimer's would be found in the A to B part of this continuum and the developmental delays and learning disabilities would be more towards the wellness side (B to C) of the continuum.

Although it could be argued that many of the stroke victims and persons with schizophrenia, cerebral palsy and neuromuscular diseases, referred to in the survey, could be in communities and thus receive occupational therapy support in communities, what is revealed in this survey is that, world-wide, occupational therapy's focus still seems to be entrenched within the illness/curative orientation and ideology, with by far the majority of occupational therapists working in psychiatric hospitals, general hospitals and rehabilitation centers. Far fewer occupational therapists are situated within the community/wellness spectrum of the continuum such as in retirement centres, day-care centers, resident care facilities and the school system. Of concern is that community-based practice ranked the lowest on the list⁴³.

A number of factors may aggravate this situation, such as there not being enough community posts, incorrect implementation of policy, or the training of therapists may not place enough emphasis on the community or wellness spectrum of intervention.

⁴¹Cipriani, J. Shah, L.J. Fox-Benscoter, M. Giardina, C. Leatherman, H. & Wood, M. (2003) **Survey of Occupational Therapy Practice in WFOT Countries**. WFOT Bulletin. November:Volume 48: 49-54

⁴² The actual survey covers the 16 most common health problems of people seen by occupational therapists but, for the purposes of this research, I have only discussed the first 8 of these.

⁴³ Ibid

Another observation from this survey was that the age group most commonly seen by occupational therapists was that of the most productive years of life i.e. from 19 to 64 years. While this is predictable, given occupational therapy's aims to increase and improve the productivity of those whose productivity may be compromised, in the South African context, the presence large numbers of children orphaned by HIV&AIDS developmentally delayed children from disadvantaged communities demands that focus on the young and developing child should become a priority and receive greater attention than is evident in the WFOT survey. Similarly, improved health care has resulted globally in larger numbers of older people living longer and requiring assistance in maintaining their occupational roles. However, this is not the case in South Africa where the high prevalence of HIV&AIDS has raised mortality rates amongst young adults. The same is true of other parts of Africa, with life expectancy dropping in some countries by 20 years to less than 46 years for men⁴⁴.

This places an additional responsibility upon occupational therapists in South Africa to find ways and means of maintaining and prolonging the productivity of those young adults who may suffer the debilitating symptoms of HIV&AIDS. It also requires that the special expertise of occupational therapy contribute to solutions relating to the provision of optimal developmental milieu for the thousands of AIDS orphans living in our country at present.

What is relevant about this is that it reveals the absolute necessity of focusing first on the needs of one's own country in reconstructing an identity for occupational therapy before focusing on the global picture.

Limitations of the FAE Model

Obviously the validity of this model needs to be tested through being extensively applied and utilized by the broader population of occupational therapists across all fields of practice and within the educational context, and because it is also amenable to other applications within other professions, would require input from these sources as well. In this way it can be evaluated for its efficacy and usefulness, and refined to produce a more perfect application.

⁴⁴ World Health Organisation. (2003). **World Health Report – Shaping the Future**. Geneva. Switzerland.

In this early stage of its application, I have tentatively exposed the model to several academic and clinical colleagues who have provided invaluable and enthusiastic feedback on it, but as I am not yet in a position to offer an in-depth critique of it I place it squarely on the table for critique by future generations of my and other professions, and by those whom we serve.

That there are limitations when using such a model is, however, acknowledged, one of these being that it tends to dichotomise what is a much more complex and multi-dimensional reality. The dual-dimensional perspective of this model lends itself specifically to an analysis of two particular ideological views, components, perspectives, etcetera. For example, in this case I have particularly focused on the medical versus social model, because this research isolated these two ideologies as being those most strongly identified in feedback from the focus group and resonance groups. In addition, South Africa's integrated national disability strategy is based upon the ideological perspective of the social model. It is thus certainly not the intention of the model as presented in this chapter to negate other issues, perspectives and ideologies but simply to use these examples to allow planners and thinkers to isolate their own particular dominant perspectives or ideological stances and manipulate the model in such a manner as to create their own '*best fit*'.

As a respected colleague and close friend, Madi Duncan, suggested to me in a fairly extensive and very helpful critique of this model, the model needs to be considered as a prototype for problematising the ideological and epistemological tensions facing the profession, but also in terms of possibly stratifying various constructs on the X-axis, such as those pertaining to practice paradigms, politics and ideologies etcetera, in which case some of the data may be bi-directional, indicating an iterative as opposed to linear approach. I see no reason why this model cannot be used in a variety of ways other than those I have represented here. For the purposes of this thesis, I leave this challenge anxiously resting on the minds of those who read this and wish to take it further.

It is important to note also that I have deliberately used medical model terminology when referring to those aspects of occupational therapy intervention on the 'medical model' side of the continuum because, as indicated in the model, therapists are still very much

under the medical model ideological influence when working in highly technical hospitals and clinics or practices where they are providing intervention/therapy at this level.

Whiteford (2007)⁴⁵ quite correctly challenges some of the assumptions made regarding the model. She suggests that only a relatively small proportion of people that occupational therapists work with are ill: for example, people who experience occupational deprivation are marginalized, not ill. Thus the illness/wellness trajectory depicted in the FAE model is not appropriate for all scenarios or all people with whom we work.

In addition Whiteford points out that the socio-political milieu within which occupational therapists interact with different sub-populations is never static, therefore to represent movement within the model as unidirectional is too simplistic. Hence the inclusion of the two bi-directional lines on the X and Y axes. Finally, and perhaps most importantly, she questions the fact that occupation is not centralized in the model, since our purpose is to “*enable occupation as it is understood, experienced and constructed in multiple contexts*” Whiteford (2007:2). She suggests a reworking of the model taking these suggestions into account.

Whiteford raises a further concern about universalizing the model, which she argues is inconsistent with the orientation of this thesis. However, this model was specifically designed for the *here and now* South African context, the *where we’ve come from and we are at this moment* context, and thus applied is appropriate in that the majority of individuals that occupational therapists are enabling in South Africa at present are either still within the ‘illness’ part of the continuum or recovering and thus, within the wellness part of the continuum, but, sadly, many are in the terminal stages of their lives.

Nevertheless, my final thesis suggests that we move in exactly the direction that Whiteford describes in her critique, and a careful reworking of the model to incorporate these aspects must therefore be considered, but I believe that for the purposes of this dissertation it adequately serves its purpose. The model’s full potential and limitations as an aid for planning and plotting various courses and scenarios need to be more intensely debated and explored.

⁴⁵ Whiteford, G (2007). External examiners report on the thesis.

Using the FAE Model to assist in transforming the curriculum

The FAE model can be used to review a particular curriculum and determine where that curriculum is located within a particular context or scenario. Thus it can assist in identifying shortcomings or gaps in the curriculum that require attention as well as identifying areas of strength that can be reinforced.

In order to use the FAE model to assist with situating oneself within a particular ideological continuum, it is obviously firstly essential to be absolutely certain of one's identity and what particular ideological principles most purely and accurately reflect one's professional identity. For these reasons I am suggesting that occupational therapy bases its restructured identity upon an ideal model which it has collectively constructed such as that depicted in diagram 8, page 274 above. This model, focusing on socio-political influences, is based upon a redefinition and reduction of those detrimental historical forces that have forced the profession into a particular mindset and an augmentation of those forces that were silenced or oppressed but which are now essential components of the South African philosophy and legislation. It is also based upon an evaluation of the nature of the professional shift that, it is suggested, is now occurring, as revealed in the focus groups, resonance groups, niche areas workshop⁴⁶ and within current progressive occupational therapy thinking.

As a process for reviewing a particular curriculum using this model, the following steps are suggested:

- The prototype of the model in diagram 4 page 267 can be used to evaluate a particular curriculum against the various (or other) criteria stated in the model according, for example, OT's role, consumer's role, aims of intervention, methods of intervention, type of contact and research focus. This will allow one to situate one's particular curriculum with some accuracy on a point upon the base line of this continuum. For the purpose of this discussion, let us suggest that your training's particular ideological standpoint falls slightly to the left on the base line with the emphasis and focus still being situated within the medical model/illness orientation: it would then be represented by point (a) as illustrated in diagram 9 below.

⁴⁶ Refer to Chapter 2 page 22 point 10 and page 36.

- Now if one draws a perpendicular line up to bisect the hypotenuse line at point (b) (see diagram 9) then the entire area to the left of this line, and the description in the columns below it, represents the particular focus and emphasis of your curriculum.
- Now using the 'ideal' model as portrayed in diagram 8 page 274⁴⁷, evaluate your particular curriculum according to how it differs or concurs with this model. If it differs extremely from the ideal, then all those criteria suggested to the right of your particular points of emphasis and focus, should guide and/or be incorporated into your transformed curriculum. Some of those aspects present within your existent curriculum will need to be reduced, de-emphasised or discarded to make way for the new. The degree of reduction of existing content is based upon the particular ethos as reflected within your particular province's health system and that of your university.
- It may also be necessary to change the degree of emphasis upon your various focus areas or ideological standpoint, as indicated in the *ideal* model, thus one may want to tweak down the red triangle and tweak up the blue triangle.

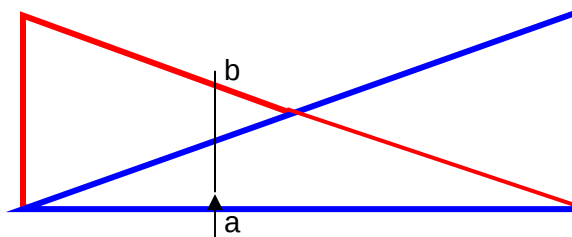


Diagram 9: Example of how to situate one's curriculum bias on the FAE Model

In a democratic society, the curriculum should not be designed according to any one particular individual's own ideological agenda, but rather in accordance with the country's needs, policies and ideologies around its people's health care and wellness and with the broad consensus within the profession as to its own identity (provided that such policies and identity are in keeping with basic human rights and compatible local and world health trends). While the wealth of experience of academic colleagues should be enlisted to inform, enrich and provide a particular character to the process of

⁴⁷Note: This so-called 'ideal' model is based upon the changes suggested by the data collected for this research and by current Government imperatives. It is not cast in stone, and it is obviously possible for curriculum planners to situate themselves within it using their own particular and unique ideals, descriptors and preferences.

curriculum design and innovation and the formation of identity, this should not be permitted to deflect attention or divert energy from the focus needs of the country.

Once the *ideal*⁴⁸ curriculum has been designed, it is implemented and as the students act it out, so the minor flaws and gaps can be addressed. Obviously a curriculum is dynamic – a process, rather than an entity - and should thus move, grow and develop with the particular needs of changing times. Once the relative *ideal* is found, specific elements within the curriculum can be isolated using the FAE model, and can be adjusted in response to particular needs and focus at any particular time in the history of that curriculum.

After FAE what next?

Over these past 12 to 15 years, occupational therapy training centers in South Africa have made substantial efforts to transform their curricula⁴⁹. The profession globally has also moved pleasingly towards a much more progressive view of what should be contained in the occupational therapy minimal standards of training.⁵⁰ The philosophy and purpose of occupational therapy programmes as set out in the World Federation of Occupational Therapy's minimal standards document are stated as follows:

"Programmes for the education of occupational therapists are guided by a unique philosophical understanding of occupation, derived from a unique mix of international and local perspectives and understandings. International perspectives address the shared understandings of occupational therapists internationally, while local perspectives address the relevance within the context of the programme" (WFOT, 2002:

⁴⁸ I place this word in italics because there is obviously no such thing as an ideal curriculum, one strives towards this and attempts to get as close to it as possible.

⁴⁹ During this period I have had the privilege and opportunity, both as external examiner and as inspector for the HPCSA for at least 7 of the 8 training centers in South Africa, to witness first hand the changes in curriculum that these training centers have made. In addition as a member of the Standards Generating Body's Task Team constituted by the HPCSA, I have had the opportunity to work together with a diverse group of academic and clinical colleagues on a proposed template for our minimal standards of training. I have been pleasantly surprised at the progressive and proactive manner in which this team has tackled this task and the results of which bear the fruits of their endeavors.

⁵⁰ World Federation of Occupational Therapists.(2002) **Revised Minimum Standards for the Education of Occupational Therapists**. Published by WFOT, P.O. Box 30, Forrest field, Western Australia.

9)⁵¹. Included in the programme's philosophical understanding of occupation is a need for *"cultural understandings about how problems with participation in occupation might be addressed and how the experience or outcomes of participation might be enhanced"* (WFOT, 2002:9).⁵² There is particular emphasis on appreciation of cultural differences and attitudes towards these.⁵³

The essential knowledge, skills and attitudes for competent practice described within the WFOT minimal standards document appears more biased towards the social/developmental and wellness side of the FAE model, which is a sign of the profession's progress globally.

Apart from carrying out a FAE analysis as a starting point to transform the curriculum, some broad principles are also suggested here as being integral to the transformation process.

First we need to **review the content of occupational therapy curricula and jettison unnecessary knowledge and include necessary knowledge**. A great deal of dead wood from the past remains in our curriculum, and this needs to be identified and thrown out. For example, one needs to ask how necessary it is to have all those many hours of anatomy, often studying certain muscles and body structures that are seldom, if ever, referred to again during the course of one's practical life. Or whether it is really necessary to do a special module or course in physics when the essential aspects of physics could be included in, for example, the kinesiology, splinting and physiology modules.

On the other hand, why are we not placing more emphasis on some applied courses in anthropology and sociology that would broaden future therapists' understanding of and insight into the various social and cultural factors relating to, and relevant to human occupation and wellness. The focus groups and workshops used to gather data for this research, suggest that occupational therapists are becoming much more involved in project management and management of relevant community programmes. More emphasis should therefore be placed on developing management and administrative

⁵¹ Ibid

⁵² Ibid

⁵³ Ibid

skills. Knowledge of policy and legislation impacting on the health and wellness of those we serve should also become an essential component within our curricula if we are to become advocates for the rights of disabled and agents of change.

These are a few examples, but what they illustrate is that somewhere something has to give. Reflective practice is essential for revisiting practice successes and gaining insight into professional reasoning processes and judgments that positively impact upon service users, practice dilemmas or other issues of concern⁵⁴. However, our professional training has repeatedly been criticised for being overloaded - students studying occupational therapy rarely have the time for adequate self study and the essential grounding in reflective practice. Thus, adding elements to the curriculum without excising others will further undermine the integrity of our degrees

Secondly, it is essential to **include all our stakeholders** in the process of transformation. These would include not only people with disabilities and their caregivers or loved ones but, particularly in view of our history and the absence of indigenous knowledge, we must include a broad spectrum of African views that will help us to think differently and more appropriately about occupation and its impact upon health in our country. Waghid⁵⁵ suggests that lecturers at South African universities need to become much more deliberative if they are to appropriate more adequately the values of an African-Africana philosophy and thereby respond better to the needs and circumstances of African learners.

The shifts that have taken place in the demographics of occupational therapy clients and students since 1994 necessitate the development not only of new practice knowledge and client/person – driven intervention in service-driven modules⁵⁶, but also the development of teaching and learning strategies and approaches.

⁵⁴Alsop, A. (2002). **Portfolios: Portraits of our professional lives**. British Journal of Occupational Therapy. Volume 65(5):201-206.

⁵⁵Waghid, Y. (2004). **Revisiting the African-Africana philosophy of education debate: Implications for university teaching**. Journal of Education, Number 34: 127-142. School of Education, University of KwaZulu-Natal, Pietermaritzburg, South Africa.

⁵⁶Whiteford, G. & St –Clair, V. (2002), **Being prepared for diversity in practice: Occupational therapy student's perceptions of valuable intercultural learning experiences**. British Journal of Occupational Therapy. Volume 65(3):129-137

Masuku van Damme (2006:13)⁵⁷ recommends intercultural dialogue between the education community, traditional health practitioners and the modern medical sector on issues of environmental health *‘to promote life quality in the face of increasing environmental crisis’*. This principle applies to all aspects of health education, not only environmental health.

Thirdly: identify knowledge that is essential and de-compartmentalise and dovetail it. Modern curricula have a tendency, through modularization and coursework, to compartmentalize knowledge. This is hugely problematic in a profession such as occupational therapy where holism is central, and where much of the knowledge necessary to practise occupational therapy forms an interwoven and integrated whole. Thus, core knowledge and reflective processes should be integrated and dovetailed into the entire curriculum not placed into tokenistic compartments⁵⁸. Thus, the business of building an understanding of and respect for cultural diversity should not simply be confined to a single anthropology module, but should become integral to all aspects and components of the entire degree.

Whiteford and St-Clair (2002:129)⁵⁹ suggest that *“awareness of, and sensitivity to, a range of health-related issues on which culture has an impact is generally accepted as an important aspect of education towards intercultural competence”*. This suggests that it is both a cognitive and affective process and as such needs to be integrated throughout all four years of training.

Fourthly: identifying core principles that must be interwoven into the entire fabric of the degree.

There are various professional attitudes and attributes that form the mortar of good occupational therapy practice. Broadmindedness, sensitivity, inclusiveness, professional integrity, assertiveness and self-reflexivity and reflective practice⁶⁰ are but a few. These cannot be incorporated as tangible components of a particular module or aspect of a

⁵⁷ Masuku van Damme, S.(2006). **Through my lenses: sustainable indigenous environmental learning in traditional healing**. African Wildlife Volume 60(1):13-15.

⁵⁸ Slattery, P.(1995):122 **Curriculum development in the postmodern era**. Garland Publishing Inc. New York & London.

⁵⁹ Whiteford, G & St –Clair V (2002).

⁶⁰ Alsop, A.(2002). **Portfolios: Portraits of our professional lives**. British Journal of Occupational Therapy. Volume 65(5):201-206.

course but form an ongoing process of conscious reflection by the student, and incremental development of such attributes and attitudes from the first lecture and fieldwork practical to the very last in the four-year degree.

Slattery⁶¹ maintains that racial issues in the postmodern curriculum should emphasise investigations of the self and investigations of the self in relation to the other, and how racism fragments the self. In view of our history, sensitizing students to each other and to racial and cultural diversity should be integrated as a principle throughout the curriculum.

Finally: Reviewing our teaching and learning methodologies and strategies. Higher education has been inundated with a plethora of new and innovative teaching methods and approaches over the past few decades. Often one or other of these becomes the fashion or mode that educators become fixated upon to the detriment of other teaching methods or approaches. Problem based learning is a typical example. Whole curricula have been converted to accommodate this approach, forcing students with a diversity of learning styles to do most of their learning within one particular style. Furthermore, particular lecturers have particular personalities that lend themselves to particular teaching methods, which often limits them largely to a single approach and leads to a suppression of their own unique and innate teaching potential in another method in which they could possibly impart knowledge in a much more effective manner.

Obviously an eclectic approach is more desirable and one that is broad enough to equitably accommodate diverse learning and teaching styles. Nash⁶² maintains that in outcomes-based learning, flexibility of learning approaches is a core factor.

In a profession such as occupational therapy, active experiential learning forms an integral part of the learning process because it not only provides opportunity for learners to put theoretical concepts into practice and thus refine their own skills and abilities, but it contains the element of interactivity between fellow-students and clients which builds greater confidence and understanding in working with diverse cultural groups.

⁶¹ Ibid

⁶² Nash, C. Flexible learning and outcomes. In: Burke, J. (1995). (Editor).

Certain aspects of the curriculum and outcomes dictate the method in which they would best be taught and thus lecturer preferences, such as using didactic teaching methods when problem based ones would be better, should not be allowed to dilute efficacy in imparting the content of a curriculum. In fact, it is suggested that when designing or transforming the curriculum, those teaching methods or approaches that would be best suited for that particular aspect of the curriculum should be identified and included at appropriate points.

Historical influences also need to be taken into account. With the desegregation of Education in South Africa in 1994, educators were suddenly thrown into situations in which they were faced with mixed race classes that had never been together on this level in the past and who were not entering the system with uniform levels of knowledge and ability. Those from previously disadvantaged schools were immediately at a disadvantage in relation to those from previously advantaged schools and required special assistance in coping with the demands of an educational system for which their preparation had been hopelessly inadequately.

Speaking from my particular experience, racial tensions and mistrust occurred which were created by the history from which the students had come and initially resulted in polarizations within classes, causing racial cliques to develop. And because most of the educators were white there was a degree of mistrust, and perceptions that white lecturers showed favoritism towards white students and discrimination against other races. In addition, the poor educational grounding of many of the African students resulted in many more of them failing tests and examinations than did the white and Indian students, who generally had a much better educational grounding. This fuelled the existing perceptions of racism held by some of the students.

Vignette # 10: Compensatory discrimination

I recall in my early and naïve years at the University of Durban-Westville, I tried to teach respect for diversity by asking students to compare their particular cultural approach to relevant aspects of a particular syllabus. I was accused by some of the African students of racism because they viewed this as me trying to show them up. When I tried to offer them extra support because of their disadvantaged educational background I was accused by some of being over-protective and “wrapping them in cotton wool”, a form of compensatory discrimination. Fortunately over the years this initial hypersensitivity and mistrust has decreased and I have learned to cope better and apply myself more effectively as a facilitator, thus interactive groups and teaching in which cultural diversity is now explored are much more relaxed, interactive and effective.

Thus it was that lecturers exposed to these complex and delicate situations had to experiment with a variety of teaching approaches. Certainly, one that has worked well is the use of interactive group learning in which the class consists partially of a didactic and partially a group-learning component. The structuring of groups to ensure cultural diversity within them enhances the potential for exchange of diverse views, values and perceptions and also provides opportunities for friendships to form across cultural lines, breaking the tendency towards cultural cliquishness.



Photo: Robin Joubert 2006

Third-year students in the Department of Occupational Therapy at the University of KwaZulu-Natal involved in interactive group learning.

It is necessary to be really creative in ensuring that the transfer of the curriculum content to the learners occurs in a meaningful and enjoyable manner and also that it provides variety to accommodate the diverse learning styles and needs of the students.

The use of a variety of case studies and video recordings of *treatment* sessions taken from various cultural and sociological backgrounds as teaching examples provides opportunity for transference of ideas, values and perceptions across the range of cultural, racial and socio-economic diversity that constitutes the student population.

Of particular importance in working with such groups is the ability to facilitate this rich interaction. White students, because of their advantaged past, often interact and present themselves more confidently in group situations. Frequently, when a question is asked of the group, students of other races may turn to the white students for their response. It is thus essential that facilitators prevent this from occurring and use the situation both to draw out reticent students who may lack self-confidence and to teach dominant and confident students to be more sensitive to allowing others to express their views. This does not mean one should suppress the views of any students, but that they should learn to be good listeners and take their turn in the process of exchange of ideas. In this way, they also learn important therapeutic skills.

The study by Whiteford and St-Clair⁶³ that focused on the lived experiences of students learning to work together with people from different social and cultural backgrounds during their education, suggests other teaching and learning methodologies to enhance the learning of culture-related concepts such as: the use of cultural vignettes drawn from student placements, the use of critical incidents as teaching tools; role-play, multi-disciplinary seminars, video segments, guest speakers, consultants, field studies and role modeling. In South Africa, many of these strategies and occasions for learning occur automatically by virtue of the very heterogeneity of our classes. This provides opportunity for rich and fertile learning and exchange around cultural and socio-economic diversity issues, which should be carefully and sensitively exploited by lecturers in occupational therapy.

⁶³ Whiteford, G. & St Clair, V. (2002).

Postcard #10: Final Comments

So the journey is now over! The roots and routes have been explored and exposed to convey the complex and powerful influence that people, forces and situations within history may exercise upon the development of a profession and its knowledge-base. A flexible model for use as a multi-dimensional evaluation and discussion tool has emerged from the process and some basic principles for transforming the occupational therapy identity and curriculum are suggested. But perhaps more important has been the investigation into the use of power and its effect upon the moulding of professional knowledge.

I have tried to enrich this exploration by sharing some of my own inner and deep personal experiences to illustrate the effects of this history and make the reading of the thesis more interesting and enjoyable. To those who wish to accuse me of narcissism for this personal self-exposure, I wish simply to state that taking such a stance has been simultaneously painful and pleasant, happy and sad, uplifting and embarrassing, but it certainly has not been easy. To those of you who have enjoyed the exposure, although it was sometimes difficult to share, I am pleased if you have benefited from it.

I end this thesis with a tremendous sense of optimism, both in my profession and in South Africa and its people. We are so rich in our diversity, and though it may sound surprising, we are privileged by our past for the very reason that we have survived it and generally come out better for it. The optimism, stoicism and resilience of most South Africans are part of this heritage and bode well for us into an uneasy and unpredictable global future. Where other races and countries may bend and break under the pressures of what possible global difficulties might lie ahead, I am convinced that we have the physical and mental constitution to stand firm.

A recent Gallup International Association⁶⁴ survey found that Africans are the most optimistic people in the world and 'hope' is Africa's most abundant harvest! What a wonderful reflection of our people considering that they have, without doubt, in recent decades faced more prolonged hardships and challenges to human survival than many other people have, yet they can still be positive!

⁶⁴ Polgreen, L.(2006). **Facing misery, Africans retain faith in future.** The New York Times, Articles selected for the Sunday Times, March 19, 2006: 1&5.

Getting to this stage of a thesis has to be one of the most awe-inspiring occasions in the life of anyone naïve enough to undertake such a mammoth task. There is a huge ambivalence between utter exhausted relief that it is all over, on the one hand, and a deep sense of loss that this thing which has dominated my life for the past five years is about to end, disappear and be lost to me. I think it can be likened to the empty nest syndrome; the child will either go out and make his or her mark on society or will disappear quietly into obscurity, to take its place like countless others on some dusty library shelf, occasionally and fleetingly referred to by some unfortunate post-graduate student. Its offspring will hopefully take the form of multiple publications that may carry the genes into the future. But whatever happens, life will never be the same again.

Tiredness envelops me

Deep

Deep

Tiredness

The journey over

Now I may lie down

In the soft green shade

Above the roots

Watching and waiting

as others taste the fruits

Spit them out

Or

Deeply

savour them.

Robin, 20 March 2006.

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Appendices:

- **Appendix A: Details of exploratory meetings.**
- **Appendix B: Letter of invitation from HPCSA**
- **Appendix C: Demographic details of focus and resonance groups.**
- **Appendix D: Letter of consent for Sam and Khulu**
- **Appendix E: Notes from workshop on 'Finding our Niche'.**
- **Appendix F: Testing the theory: Details of related publications and conference presentations**
- **Appendix G: Lists of members of working groups for task teams: Year of Disabled**
- **Appendix H: Analysed package of SAQA submissions and focus groups which was sent out to resonance group members.**

APPENDIX A.

EXPLORATORY MEETINGS: Tabulation of sources and outcomes of these meetings - in the early stages of proposal development, preliminary meetings were held to literally “air my views and ideas” and bounce ideas off fellow colleagues. As the research progressed I used any opportunity I could to share my progress with respected colleagues and obtain their views. Although I did not tape these meetings or take down detailed notes, I used their inputs to inform my work as it progressed. The following is a summary of the meeting held:

WITH WHOM	WHEN	WHERE	OPPORTUNISTIC CIRCUMSTANCE	PURPOSE
With four 4 academic staff of the University of Durban Westville	23 October 2002	Occupational Therapy Department of the University of Durban-Westville, Durban	Pre-arranged	Sharing initial developments and bouncing ideas off colleagues
9 occupational therapy lecturers and 4 clinicians	4 November 2002,	Roseberry Lodge, Mowbray, Cape Town	Was in Cape Town as External Examiner for UCT	Presenting my initial ideas and obtaining cooperation of participants as Resonance Group members ¹
Prof Ruth Watson (Prof Emeritas) OT Department UCT	November 2002	Occupational Therapy Dept. UCT	Was in Cape Town as External Examiner for UCT	As experienced and respected OT academic and qualitative researcher, I valued her particular views on my progress.
Prof Ruth Watson (Prof Emeritas) OT Department UCT	November 2003	Occupational Therapy Dept. UCT	Was in Cape Town as External Examiner for UCT	To report back on changes and progress from previous meeting.
Madi Duncan and Helen Buchanan lecturers in Occupational Therapy in Cape Town	15 October 2004	Over lunch in a Restaurant in Cape Town	Was in Cape Town for a family Wedding and best friends 50 th birthday celebrations	Discussed my progress to that date and obtained their views on this
Margot Graham Head of Department of Occupational Therapy at the University of Pretoria	Circa June/July 2004	At Johannesburg International Airport	As external Examiner for Course work Masters (Community)	General discussion about ideas that were formulating.

¹ Resonance Groups are described in Chapter 2 on page 27 .

WITH WHOM	WHEN	WHERE	OPPORTUNISTIC CIRCUMSTANCE	PURPOSE
Mrs Susan Beukes, Head of Department of Occupational Therapy, University of Stellenbosch	November 2004	Abigail's B&B, Parktown, Johannesburg	Mrs Beukes and I were invited by HPCSA to inspect the Occupational Therapy Degree at Wits University	To obtain a respected colleagues views on my research.
Prof SBrintnell University of Alberta, Canada.	August 2005	Serengetti Tanzania	Informal feedback over evening drinks following my key note presentation at the OTARG conference	To provide me with very valid perspectives from a source outside of South Africa

Table 7: Details of Exploratory meetings.

APPENDIX B

Letter from HPCSA inviting researcher to participate in the SGB working group.

PROFESSIONAL BOARD FOR OCCUPATIONAL THERAPY AND MEDICAL ORTHOTICS/PROSTHETICS

Ms R Joubert
Department of Occupational Therapy
Faculty of Health Sciences
(Westville)
University of KwaZulu Natal
Private Bag X 54001
DURBAN
4000

DEPT: PROFESSIONAL BOARDS
SENIOR MANAGER: J H COETZER

My ref: 31/8/1
Mrs A Taljaard x 338 9349/nan

11 November 2004

Dear Ms Joubert

STANDARDS GENERATING BODY (SGB) WORKSHOP 2 - 3 DECEMBER 2004

The Professional Board for Occupational Therapy and Medical Orthotics/Prosthetics in October 2003 resolved that it be recommended to the newly elected Professional Board that the standard generating functions be performed by the Education Committee, and in particular, the SGB Working Groups of the different professions according to guidelines proposed by the Education Committee and a template be developed by the Education Committee.

The Professional Board for Occupational Therapy and Medical Orthotics/Prosthetics at a meeting in October 2004 confirmed the recommendations of the Education Committee and Combined Education Committee in terms of the appointment of representatives on the SGB Working Group.

The following persons were appointed to the SGB Working Groups, namely

SGB Working Group for Occupational Therapy

- * Mrs S Beukes (Convenor)
- * Ms K E Holland
- * Ms T Caga
- * Mr O S Ribisi

SGB Working Group for Medical Orthotics/Prosthetics

- * Mr J Swanepoel (Convenor)
- * Mr A Visser
- * Mr M Chundriah
- * Mr M Mitchell
- * Mr R Knight
- * Mr M Schmidt

Working Group for Arts Therapy

- * Ms H Schiff (Convenor)
- * Prof M Pavlicevic
- * Ms L Souchon
- * Ms K Meyer
- * Ms A Fiske

The Professional Board for Occupational Therapy and Medical Orthotics/Prosthetics also resolved that all Heads of Educational Institutions, not already represented on the SGB Working Group, and representatives from OTASA also be invited to attend the Workshop.

Ms K Holland would be unable to attend the Workshop and it was agreed that she be replaced by Ms R Joubert.

The SGB brief was to determine the needs of the country and to generate standards in order to have a registerable qualification in line with the SAQA requirements.

The Professional Board resolved that a SGB Workshop be conducted and that Ms M Kelly, Assistant Director, Health Sciences and Social Sciences, SAQA be invited to facilitate part of the Workshop.

The Workshop will be conducted as follows

Date: 2 and 3 December 2004

Time: 2 December 2004: 10:00 – 17:00
3 December 2004: 09:00 – 16:00

Venue: Conference Centre
Burgerspark Hotel
Van der Walt Street
PRETORIA

It would be appreciated if you could kindly make your travel arrangements as follows:

Ms Henriette Theron
Travel-4-Fun
Tel: (012) 345 6438
E-Mail: hi@travel-4-fun.com

You are kindly invited to the SGB Workshop and it would be appreciated if you could kindly confirm whether you would be in a position to attend the Workshop. Should you have any queries, please do not hesitate to contact Ms A Nkosi at (012) 338 9380, e-mail AbegailN@hpcsa.co.za.

On behalf of the Professional Board for Occupational Therapy and Medical Orthotics/Prosthetics, I wish to thank you for your kind co-operation in this matter.

Yours faithfully

MRS A TALJAARD
PROFESSIONAL BOARD MANAGER

ADDENDUM

PROFESSIONAL BOARD FOR PROFESSIONAL BOARD FOR OCCUPATIONAL THERAPY AND MEDICAL ORTHOTICS/PROSTHETICS

SGB WORKING GROUP

LIST OF MEMBERS

NAME	INSTITUTION	POSTAL ADDRESS	PHYSICAL ADDRESS	TEL NO./E-MAIL/FAX NO
CHAIRPERSON: PROFESSIONAL BOARD FOR OCCUPATIONAL THERAPY AND MEDICAL ORTHOTICS/PROSTHETICS				
Dr R B Crouch	HPCSA	P O Box 95657 GRANTPARK 2051	35 Orange Road Gardens JOHANNESBURG 2193	Tel: 011 728 2652 Fax: 011 728 4575 (a/h) Cell: 082 892 2946 E-mail: rcrouch@intekom.co.za
SGB WORKING GROUP FOR OCCUPATIONAL THERAPY				
Mrs S Beukes (Convenor)	HPCSA	11 Springbok Street Loevenstein BELLVILLE 7530		Tel: 021 938 9305 (w) Fax: 021 938 9308 Cell: 083 287 4851 E-mail: sbeuk@sun.ac.za
↓ Ms R Joubert	University of KwaZulu-Natal	Department of Occupational Therapy University of KwaZulu-Natal Westville Campus Private Bag X54001 DURBAN 4000		Tel: 031 260 7953 Fax: 031 260 7227 Dell: 083 482 1799 E-mail: joubetr@ukzn.ac.za
Ms T Caga	HPCSA	P O Box 61116 BLUEWATERBAY 6212	Dora Ngiza Hospital Paediatric Burn Unit Uitenhage Road	Tel: 041 406 4227 (w) Fax: 041 453 9059

NAME	INSTITUTION	POSTAL ADDRESS	PHYSICAL ADDRESS	TEL NO/E-MAIL/FAX NO
			Algoa Park PORT ELIZABETH 6001	Cell: 083 737 4731 E-mail: tabisancaga@hotmail.com
Mr O S Ribisi	HPCSA	P O Box 1002 GROOTHOEK HOSPITAL 0628	Dept Occupational Therapy Lebowakgomo Hospital Private Bag X14 CHUENESPOORT 0745	Tel: 015 632 6900 Fax: 015 632 6718 Cell: 084 734 6496
Ms Ks Holland	University of KwaZulu-Natal	Department of Occupational Therapy University of KwaZulu-Natal Westville Campus Private Bag X54001 DURBAN 4000	Department of Occupational Therapy Room E5 531 Block E Westville Campus University Road off Essex Terrace Westriding DURBAN 4000	Tel: 031 260 7402 Fax: 031 260 7227 Dell: 083 790 4111 E-mail: hollandk@ukzn.ac.za
SGB WORKING GROUP FOR MEDICAL ORTHOTICS/PROSTHETICS				
Mr J Swanepoel (Convenor)	Tshwane University of Technology	Division Medical Orthotics & Prosthetics Private Bag X680 PRETORIA 0001	Tshwane University of Technology Department Sport and Physical Rehabilitation Room 430 Building 2A	Tel: 012 318 5765 Fax: 012 318 4792 E-mail: swanepoeljs@tut.ac.za
Mr A J Visser	HPCSA	59 Boshoff Street Flora Park POLOKWANE 0699	108 Potgieter Avenue Weigelgen POLOKWANE 0699	Tel: 015 287 5240 Fax: 015 297 2604 015 287 5505 Cell: 082 459 4479 E-mail: vissera@dhw.norprov.gov.

NAME	INSTITUTION	POSTAL ADDRESS	PHYSICAL ADDRESS	TEL NO./E-MAIL/FAX NO
Mr M Chundriah	HPCSA	55 Teal Close Woodhaven DURBAN 4004		Tel: 031 461 1546 Fax: 031 461 2887 Cell: 084 446 2284 E-mail: chundriah@dohwent.kzntl.gov.za
Mr M Mitchell	HPCSA	13 Colebrook Street ATLANTIS 7349		Tel: 021 531 5300 (w) Fax: 021 531 3620 Cell: 083 666 7628
Mr R Knight	SAOPA	P O Box 27011 Greenacres PORT ELIZABETH 6045	23 Pickering Street Newtonpark PORT ELIZABETH 6045	Tel: 041 363 9781 Fax: 041 363 1551 E-mail: knightr@iafrica.com
Ms M Schmidt		Orthopaedic Centre Private Bag A14 Klerksdorp Hospital KLERKSDORP 2570	C/o John Ohr/Church Street Klerksdorp Hospital KLERKSDORP	Tel: 018 406 4546 Fax: 018 462 3178 E-mail: mschmidt@nwpg.gov.za
SGB WORKING GROUP FOR ARTS THERAPY				
Ms H Schiff (Convenor)	HPCSA	44 Jordaan Street Bo Kaap CAPE TOWN 8001		Tel: 021 422 3438 Cell: 072 199 9888 E-mail: heathers@intekom.co.za
Prof M Pavlicevic	University of Pretoria	Department of Music Musaion Room 3-13 University of Pretoria PRETORIA		Tel: 012 420 5372 Fax: 011 420 4517 E-mail: mercedes@up.ac.za

NAME	INSTITUTION	POSTAL ADDRESS	PHYSICAL ADDRESS	TEL NO./E-MAIL/FAX NO
Ms A Rackstraw	The Community Arts Therapy Programme (CATH) Cape Town	22 Alpina Road CLAREMONT 7700	22 Alpina Road CLAREMONT 7700	Tel: (021) 683 9654 E-mail: anorack@mwweb.co.za
Ms K Meyer	SANATO (Gauteng)	10 9 th Street MELLVILLE 2092	10 9 th Street MELLVILLE 2092	Tel: 011 482 5541 Cell: 083 600 2453 E-mail: kirstm@iafrica.com
Ms A Fiske	University of Cape Town	15 Riesling Road CONSTANTIA 7806	15 Riesling Road CONSTANTIA 7806	Tel: 021 762 7666 (w) 021 794 1644 (h) Cell: 072 210 8708 E-mail: paliske@mwweb.co.za

HEADS OF EDUCATIONAL INSTITUTIONS: OCCUPATIONAL THERAPY

Dr M Graham	University of Pretoria	Department of Occupational Therapy Faculty of Medicine University of Pretoria P O Box 667 PRETORIA 0001	Dept of Occupational Therapy S.G. Lourens Building Soutpansberg PRETORIA 0001 <i>Merid</i>	Tel: 012 329 7800 Fax: 012 329 3255/329 7850 E-mail: istanton@postino.up.ac.za margot.graham@up.ac.za
Dr V Janse van Rensburg	University of the Western Cape	Academic Development Unit Department Occupational Therapy Faculty of Community & Health Science University of the Western Cape Private Bag X17 BELLVILLE 7535		Tel: 021 959 2279 E-mail: vvanrensburg@uwc.ac.za jdejongh@uwc.ac.za
Prof L van Niekerk	University of Cape Town	Division of Occupational Therapy School of Health & Behavioural Sciences	Zone F45, Old Main Building Groote Schuur Hospital OBSERVATORY	Tel: 021 406 6048 (w) Fax: 021 406 6323

07 Not mainly List

NAME	INSTITUTION	POSTAL ADDRESS	PHYSICAL ADDRESS	TEL NO./E-MAIL/FAX NO
		Rehabilitation Sciences Univ of Cape Town Zone F45, Old Main Building Groote Schuur Hospital OBSERVATORY 7505		E-mail: lvnkerk@uctgsh1.uct.ac.za
Dr S van Vuuren	University of the Free State	Dept of Occupational Therapy Faculty of Medicine Univ of the Free State P O Box 339 BLOEMFONTEIN 9300	Occupational Therapy Department C de Wet Building G44 University of the Free State BLOEMFONTEIN 9300	Tel: 051 401 3319 Fax: 051 401 3288 E-mail: gnatsvv.md@mail.uovs.ac.za
Mrs P de Witt	University of the Witwatersrand	The Head Dept of Occupational Therapy Faculty of Health Science University of the Witwatersrand 7 York Road PARKTOWN 2193	Ms D Franzsen Head of Department Occupational Therapy Dept Conicher Building, Office 3 Education Campus Univ of the Witwatersrand St Andrew Road Parktown, JHB	Tel: 011 717 3703(w) Fax: 011 717 3709 Cell: 082 817 6946 E-mail: dewittpa@therapy.wits.ac.za
Mr A Ramukumba	University of Limpopo MEDUNSA Campus	Dept of Occupational Therapy Faculty of Medicine University of Limpopo P O Box 501 MEDUNSA 0204	Room 117, Ground Floor Dept of Occupational Therapy Health Sciences Building Medunsa	Tel: 012 521 4495 Fax: 012 521 5730 E-mail: alfred@ul.ac.za aramukumba@hotmail.com
Mrs S Beukes	University of Stellenbosch	Department Occupational Therapy Faculty of Medicine University of Stellenbosch P O Box 19063 TYGERBERG 7505		Tel: 021 938 9305 (w) Fax: 021 938 9308 Cell: 083 287 4851 E-mail: sbeuk@sun.ac.za

MEDICAL ORTHOTICS/PROSTHETICS

NAME	INSTITUTION	POSTAL ADDRESS	PHYSICAL ADDRESS	TEL NO./E-MAIL/FAX NO
Mr J Swanepoel (Convenor)	Tshwane University of Technology	Division Medical Orthotics & Prosthetics	Tshwane University of Technology Pharmaceutical and Physical	Tel: 012 318 5765

NAME	INSTITUTION	POSTAL ADDRESS	PHYSICAL ADDRESS	TEL NO./E-MAIL/FAX NO
		Private Bag X680 PRETORIA 0001	Rehabilitation Room 430 Building 2A	Fax: 012 318 4792 E-mail: swanepoehs@tut.ac.za
ARTS THERAPY				
Prof M Pavlicevic	University of Pretoria	Department of Music Musaion Room 3-13 University of Pretoria PRETORIA		Tel: 012 420 5372 Fax: 011 420 4517 E-mail: mercedes@up.ac.za
REPRESENTATIVES FROM OTASA				
Ms A Lesunyane		Department of Occupational Therapy Medunsa P O Box 156 MEDUNSA 0204		Tel: 012 521 4133 Fax: 021 521 5730 E-mail: annah@medunsa.co.za
Ms S Misbach	Department of Health Metropole District Health Services Provincial Government Western Cape	Metropole District Health Services: Public Health Programme C/o Karl Bremer Hospital Nurses Home PAROW 7570		Tel: 021 918 1286/1654 (w) 021 448 0340 (h) Fax: 021 949 8153 Cell: 073 350 3399 E-mail: smisbach@pgwc.gov.za
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Ms E Burger	Gauteng Department of Health	Gauteng Health Private Bag X085	C/o Market & Saver Street MARSHALLTOWN	Tel: 011 355 3432

NAME	INSTITUTION	POSTAL ADDRESS	PHYSICAL ADDRESS	TEL NO./E-MAIL/FAX NO
		MARSHALLTOWN 2107	2107	Fax: 011 355 3400 E-mail: elmab@gpg.gov.za
Ms H Pitout		17 Greenleaves Riverview Road CLUBVIEW 0157	Pretoria Academic Hospital Private Bag X169 PRETORIA 0001	Tel: (012) 354 1093 (w) Fax: (012) 354 6101 Cell: 072 171 0462

Updated: 23 March 2005

Details of Focus Groups and Resonance Groups.

1) DEMOGRAPHIC BREAKDOWN OF FOCUS GROUPS:

Focus group No. 1	Location: Pretoria	Focus Group No. 2	Location. Johannesburg
1. Race: African	1	1. Race: African	0
Indian	0	Indian	1
White	4	White	3
Mixed	0	Mixed	0
2. Gender: Female	5	2. Gender: Female	4
Male	0	Male	0
3. Age range: 20-29	1	3. Age range: 20-29	2
30-39	2	30-39	0
40-49	1	40-49	1
50-60	1	50-60	1
>60	0	>60	0
4. Work Status		4. Work Status	
Practitioner	0	Practitioner	0
Academic	3	Academic	2
Both	2	Both	2
5. Field: Physical	2	5. Field: Physical	2
Psychiatric	3	Psychiatric	2

Table 8: Focus Groups 1 and 2 located in Gauteng Province

Focus group No. 3	Location: Durban	Focus Group No. 2	Location: Bloemfontein
1. Race: African	3	1. Race: African	0
Indian	2	Indian	0
White	1	White	5
Mixed	1	Mixed	0
2. Gender: Female	6	2. Gender: Female	4
Male	1	Male	1
3. Age range: 20-29	2	3. Age range: 20-29	2
30-39	2	30-39	1
40-49	1	40-49	1
50-60	1	50-60	0
>60	0	>60	1
4. Work Status		4. Work Status	
Practitioner	2	Practitioner	2
Academic	4	Academic	3
Both	1	Both	0
5. Field: Physical	4	5. Field: Physical	4
Psychiatric	3	Psychiatric	1

Table 9: Focus Groups 2 and 3 located in KwaZulu-Natal and Free State Provinces.

2. Demographic Breakdown of Resonance Groups:

Participant code no		Race	Professional Status	Age group
1	A	white	lecturer	50-60
2	B	white	senior clinician	50-60
3	C	white	lecturer/clinician	40-50
4	D	Indian	lecturer/clinician	30-40
5	E	white	lecturer	40-50
6	F	white	lecturer	50-60
7	G	white	lecturer	50-60
8	H	white	private practice	60+
9	I	white	lecturer	30-40
10	J	white	lecturer	30-40
11	K	white	lecturer	40-50
12	L	African	Clinician/management	20-30

Table 10: Breakdown of Resonance Groups.

APPENDIX D

Letter of consent for Sam and Khulu

Preamble/ permission and instructions to participants with disabilities regarding their ESSAYS:

Interview.

Before we commence I would like you to know about my research, its purpose and what I expect of/ from you. (this will be verbally explained using an interpreter if and where necessary) You are under absolutely no obligation to participate in this interview and essay writing project if you do not wish to. If however you agree to participate, you may elect that the information you provide will be used anonymously in my research (in other words if I quote anything you may say I will not mention your name or anything about you that may lead people who know you to guess who you are.) or you may agree to be acknowledged for your contribution to it and to have your photograph published in the research. If you are under age or physically unable to sign agreement you need your parents to sign on your behalf.

I ~~am~~am under age and/or unable to physically write my name and therefore agree to participate in providing Ms Robin Joubert with the details she asks of me and in addition I agree to write her an essay about my experiences of rehabilitation and being disabled in South Africa.

- I am in agreement that she may use my name and picture within her research publication (cross out the sentence if you don't agree)
- I request that she will, under no circumstances, provide any information about my name or residence, within her research.

In the event of my being unable to write my name or under the age of 21 years I appoint a proxy /parent/guardian to sign on my behalf.

Signed.....Name in full.....

Designation: e.g. parent/guardian:.....

Date...24 January 2005...in.....

ID Number:.....

(This section below to be completed by researcher)

Number :.....

1. Age: 20

Gender: M

Race: A

2. Schooling: 12 years

3. Work history or training after school: 1 year

4. Family background: 1st generation

5. Nature of disability: (Medical description)

Physical disability

APPENDIX E

Notes from Workshop on 'Finding our Niche'.

DATE: 15/06/04.

FINDING OUR NICHE: REPORT BACK FROM SUB-COMMITTEE ON "OUR PROFESSION". A WORKSHOP HELD AT THE OCCUPATIONAL THERAPY DEPARTMENT OF THE UNIVERSITY OF KWAZULU-NATAL.

Introduction: Part of the directive of this sub-committee was to explore the different perspectives of clinical and academic therapists about what they felt the focus of our profession was in these current times and in particular where our particular *niche* was. To this end a workshop was arranged at the Occupational Therapy Department at UKZN to which both academics from the department and clinicians from the greater Durban and Pietermaritzburg metropolitan areas were invited.

Process: There was a relatively good turnout for the workshop of approximately 20 participants representing physical, psychiatric and paediatric fields of practice as well as the academic component. The seminar room in which the workshop was held was divided into 4 tables that could take up to 6 participants each and as members registered they sat at various tables which were later used as the various groups.

1. Julie Lingah welcomed the participants and explained the purpose of the workshop which was to??????

2. Thereafter Robin Joubert shared some of the findings of her current research for the D.Ed degree. These included the results of focus group analysis which revealed the national perspectives of therapists regarding how the profession has changed in the past 20 years as well as identity problems facing the profession, challenges facing the profession and the changing profile of roleplayers and stakeholders related to OT. (see annexure attached: Summary of analysis of focus groups pages 3 to 6). Participants were asked to add additional points which they thought were relevant to each section.

Participants were then informed that as they sat at each table these tables would form the groups 1,2,3 and 4. They were instructed to select a facilitator and scribe; briefly share the groups views on each topic that they were given; describe what processes could be put in place to resolve/improve the problem/situation; and where applicable to mention who should be responsible and to give it a time frame.

- Group 1 was asked to deal with identity problems i.e. conflict around models used in OT; searching for a NICHE for ourselves; the adequacy of our scientific basis for practice;
- Group 2 dealt with: Poaching by other health professionals; the blurring of roles caused by the new health system; The impact of alternative therapies.
- Group 3 dealt with: the changing role and profile of OT and challenges

- Group 4 dealt with: The changing profiles of stakeholders and roleplayers.

Groups were given approximately 45 minutes to discuss the issues they were allocated and then to report these back to a plenary session at the end using overhead transparencies. The following feedback was given:

Group 1:

a) Conflict around models influencing OT:

Groups views:	• Consideration should be given to combining two or more models which are relevant to OT and extracting the best of each, depending on the therapeutic setting. • Students need a sound base on the theories and reorientation should be holistic, reductionist and very NB that students have a clear understanding of these e.g. creative participation.
Process put in place to resolve improve the situation	Levels of rehabilitation care should be matched with phases of intervention? (ask
Who should be responsible?	Training centers and OTs in general
Time frame?	Not given.

Discussion: Robin expressed concern that we were not investigating more indigenous knowledge systems to create our own models such as "ubuntu", Also the need to develop, research and market our model of Creative Participation more.

b) Need for a better scientific base for OT

Groups views:	There is not enough research emphasising professional development
Process put in place to resolve improve the situation	• Students need to ability to access information e.g. internet • They need a sound scientific basis from their training • More emphasis on formal standardised assessments • More scientific treatment procedures and case write ups have formal tests e.g. MSE Oxford standard etc). • More information of data gathering and storing • Lack of Afrocentric standardised tests.
Who should be responsible?	Not stipulated but judging from the above it looks like Training centres should take responsibility.
Time frame?	Not given

c) OT NICHE AREAS:

Groups views:	Should focus on human occupation
Process put in place to resolve improve the situtation	Students should be taught: • Need a sound theoretical framework • need more supporting research to show what we do works • Recording and reporting effectively • Demonstrate evidence of treatment outcomes ?EBP • Assertiveness and confidence • More indigenous knowledge
Who should be responsible?	? training centers
Time frame?	Not given

Group 3 felt that our main NICHE area was the fact that we were human occupation experts

GROUP 2:

a) POACHING

Groups views:	2 Typical areas of poaching identified by group were stress management which social workers are now doing and vocational rehabilitation which nurses are doing. The group felt this was an underhanded compliment and that it was proof that we must be doing something right.
Process put in place to resolve improve the situtation	OTs need to contribute more in ward rounds and share activity findings? Sharing treatment progress
Who should be responsible?	All OTs
Time frame?	Not given

b) BLURRING OF ROLES: Group felt the problem was due to the fact that organisations did not feel that OT is a necessary part of the team and hence blurred roles as they take over OT role. Relates to the problem of OT identity and marketing.

c) IMPACT OF ALTERNATIVE THERAPIES. Group felt we lack confidence and need to market ourselves better and rebuild our professional identity. Felt there was too much information given at undergraduate level and this detracted from the ability to become real experts in human occupation. The group actually questioned whether we were human occupation experts.

GROUP 3: Changing profiles of OT and Identity problems and challenges:

Problems: Changing profiles:

- Fewer OTs going into psyche OT
- Urgent need to have better marketers of the profession]
- Client populations increasing and changing
- Greater need for quality assurance and better work ethic and professionalism (accreditation of services seems to be assisting with this in public sector and ? private?)
- Greater need for adequate understanding of management of services and administrative procedures related to running various types of departments.
- Large populations versus individual therapy
- Need to have good understanding of Government policy and legislation
- Greater understanding of medico-legal process and procedures
- Ability to work with limited resources
- Need to refocus and improve on NICHE area of human occupation.

Problems: identity problems:

- Limited resources i.t.o. OT numbers to really make an impact
- Low recognition due to low visibility in Govt. services
- Impact of alternative therapy on profession
- Stick to fact that we're human occupation experts.

Challenges facing OTs:

Need more SPECIALISATION and clear career path too much "jack of all trades and master of none." OTs need more opportunity to grow and the OT role should be clearly defined. Solution also we need to market ourselves better

MARKETTING THE PROFESSION:

- OT s not adequately sure of themselves or confident, there aren't enough fighters OTs are too passive
- OTs not pro-active
- Occupational therapy versus being occupied, there is a persistent ignorance about OT from both professional groups and the community at large
- OTs need to educate other professionals better.

OTS HAVING TO COPE WITH MUCH MORE COMPLICATED CASES
MANY ALSO HAVE MAJOR SOCIAL PROBLEMS/ISSUES.e.g. dual
multiple pathologies e.g. HIV/AIDS complex, very limited resources
combinations of physical, psyche and social issues.

GREATER NEED FOR AWARENESS OF RELEVANT POLICY AND
LEGISLATION.

- OTs have become more involved in decision making and policy development as well as having to understand the implications and contents of policies and legislation
- SA OTs have to deal with many diverse populations and cultures.

GROUP 4: CHANGING PROFILES OF ROLEPLAYERS AND STAKEHOLDERS:

1. Patient Profile:

- More children with diseases such as arthritis, diabetes, depression and anxiety
- Complexity in terms of: More patients with multiple diagnoses and social problems
- Lifestyle diagnosis
- Short stay i.e. more acute cases

RECOMMENDATIONS:

- Fill in the gap between hospital and community services (difference in resources)
- Students learn to treat multiple diagnoses while training maybe clinicians need top up?

2. Stakeholders:

- Much greater contact with caregivers need more care-provider training, home based care, care at all levels
- Community health workers
- Insurance companies/legal fraternity (post graduate training? Very skilled and need to be excellent report writers)

3. Numbers/areas of work:

- Geographical distribution may be wide spread
- New health system takes services to the people
- More community based work = patient and family taken into consideration.

RECOMMENDATIONS:

- OT s need to be motivated and have incentives to work in community and far outlying areas
 - Concern about what's going to happen to psyche OTs.
4. Mentoring/ monitoring of ot at all levels (in order to ensure maintenance of standards):
- Need good role models
 - Telemedicine for OTs in Community Service
Academic development –
 - Need to investigate benefits of Internship vs mentorship to ensure quality assurance of services. Suggest the National Forum and DOH investigate this
 - Other issues i.e. OTs need to be familiar with policy documents and medico legal work but this is more for post-graduate work.
 - Clinicians have need for more coursework masters P>G> degrees to be able to improve their skills, speciality areas etc.

The way forward:

1. Robin to record findings of groups and submit for discussion at UKZN OT Department's planning meeting.
2. Send to OT Forum for discussion
3. Need to develop more post graduate (course work) diplomas and degrees for clinicians
4. develop a really good website to market OT (it was pointed out that this already exists)
5. Make better use of OT week to market OT
6. Write articles about success stories in popular magazines etc.

APPENDIX F

**Testing the theory: Details of related publications and
conference presentations.**

South African Journal of Occupational Therapy

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Evidence-based practice: a critique based on occupational therapy within the SA context

R. JOUBERT

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Abstract

This article will briefly examine evidence-based practice (EBP), summarise some of its most obvious merits and thereafter explore its appropriateness and relevance for South African occupational therapy. In conclusion, ways in which it is possible to apply the principles of EBP to the South African occupational therapy education and clinical context in a more realistic manner are suggested.

Keywords: South Africa, evidence-based practice, indigenous knowledge systems, accessibility, research, accountability, quality assurance

Introduction

The purpose of this article is to provide South African occupational therapists with some food for thought around evidence-based practice (EBP). South African occupational therapists have a tendency to accept most of what they are fed from occupational therapists in western countries, often importing their ideas, assessment batteries and models lock, stock and barrel, without adequately interrogating their applicability and appropriateness to South Africa's very specific and unique context. South African occupational therapy is on the threshold of playing a critically important role in contributing to preventing ill health and promoting the health and wellness of South Africans and other Africans¹. In a world characterised by conditions such as occupational overload*, occupational deprivation², occupational apartheid³, together with the HIV/Aids pandemic and the many occupational dysfunctions that physical or psychological impairments cause, occupational therapists have an enormous role to play and many challenges ahead of them.

In order to fulfil this role, South African occupational therapists have to become critical thinkers, able to challenge not only socio-political issues that impact upon the health and wellness of individuals in their own country, but also the trends and vogues that from time to time preoccupy the profession, especially those that come from outside South Africa. This article is thus intended to be provocative. It presents readers with some of the concerns the author has about EBP and its applicability to South Africa.

Margo Holm⁴, Director of Post Professional Occupational Therapy Education at Pittsburgh University in the United States, titled her 2000 Eleanor Clark Slagle lecture "*Our Mandate for the New Millenium: Evidence-Based Practice*". Before and since then, there has been a plethora of articles in American, British, Canadian and Australian occupational therapy journals debating and mostly endorsing EBP. To do real justice to this topic would take several articles of substantial length; however, the aim of this article is to out-

line some personal views and concerns related to EBP in occupational therapy, its relevance to the South African context and how it impacts upon occupational therapy education.

Sackett *et al* defined EBP as "*the conscientious, explicit and judicious use of current best evidence in making decisions about the care of individual patients.*"⁵ Evidence in this context generally means evidence synonymous with quantitative research. This is supported by the fact that Taylor⁵ informs us that the phrase was first coined at McMaster University's Medical School and thus it was born within a medical model and positivist framework. Its epistemology is thus likely to have been strongly influenced by the medical model, a point that will be revisited later in this article. Sackett *et al*⁵ also made it clear that EBP was only part of the clinical decision-making process and that the entire process should be based on a mix of evidence from research and clinical expertise.

Sackett and Haynes⁶ suggested that the process of implementing EBP should follow five steps.

1. Formulate the problem by converting information needs into answerable questions.
2. Track down the best evidence with which to answer the questions.
3. Critically appraise the evidence, assessing its validity and usefulness.
4. Implement the most valid and applicable findings in one's own practice.
5. Evaluate one's performance in the light of the new evidence.

In addition, the research evidence used should be evaluated against a hierarchy to establish where it falls on a continuum of best evidence to worst evidence. Obviously, one should try and make use of only the best evidence. Holm⁴ describes five hierarchical levels. (See Table I). The majority of the levels are based upon quantitative research designs and the qualitative designs are classified at the lowest level of the hierarchy. This issue will be discussed later in the article.

* Occupational overload is a term coined by the author to describe current global trends in which the expectations brought about by modern technology and highly competitive, mostly capitalist societies, has resulted in inordinate occupational demands upon individuals, which, in turn, have impacted negatively upon the physical and mental health of such individuals.

Table I: Hierarchical levels of evidence

Level	Design	Type of evidence
I	Systematic review and meta-analytic study.	Strongest, based on very rigorous methodology.
II	Randomised Control Studies.	
III	Trials without randomisation.	
IV	Non-experimental studies.	Lowest level on the hierarchy.
V	Opinions of respected authorities (these also include qualitative designs).	

Margo Holm (2000) based on *Hierarchy* by Moore et al.

The merits of EBP

It would be both incomplete and unfair not to examine EBP's merits. The following are some of its more important merits, but the list is by no means exhaustive.

- It provides a method of informing occupational therapists whether what they are doing and how they are doing it really works⁴.
- It guides occupational therapists in selecting the best tried-and-tested occupational therapy practices to treat various problems.
- It enhances clinical reasoning in order to achieve the collaborative goals set together with the client⁶.
- It provides a level of accountability for the therapist.
- It is a sophisticated method of trying to assure quality treatment.
- In this age of consumerism, providers of health care need to carefully manage the growing gap between what can be done and what can be afforded. Most of the private sector health care today is payer-driven, and purchasers of a service require that it be accredited before they will contract such a service.
- It contributes towards decisions about the cost effectiveness of certain interventions.
- It questions the traditional authority and skills of the so-called "expert".
- It keeps clinicians updated on a specific type of knowledge emerging around occupational therapy⁵.
- It improves the ability and confidence of occupational therapists to use the Internet (if they have access to it).
- It gives the team a framework for group problem solving.
- It may allow therapists to better communicate to patients the rationale behind treatment decisions.
- It should hopefully provide impetus for occupational therapists to do more research to add to the existing, rather empty, occupational therapy research coffers.

Why should EBP in occupational therapy be carefully considered within the South African context?

1. Indigenous knowledge systems (IKS) versus the western world or "first" world

Africa, particularly South Africa, is finally emerging from the remnants of colonialism and apartheid, an era in which it was compartmentalised and marginalised into the worst and most derogatory category when compared with the western world: for example, third world versus first world, developing versus developed, disadvantaged versus advantaged. This emergence is particularly dynamic in South Africa and will be discussed in more detail in point 2 below.

For too long now, we have been dominated by western knowledge systems and hegemony. It is long overdue that we begin to look within our own indigenous knowledge systems

and within the specific knowledge generated through our unique experiences as South African occupational therapists. We need to question the knowledge we have for so long been soaking up uncritically like sponges.

At the Ingede, African Scholarship Conference in Durban in March 2004, respected Ghanaian writer Kofi Awoonor⁷ maintained that one of Africa's biggest problems lay in the abysmal failure of African intellectuals to interrogate the nature, function, features and characteristics of knowledge systems that had absolutely nothing to do with Africa. Why do we not interrogate the epistemology of western thought and its applicability to Africa?

While there is a growing body of qualitative research being added as evidence within the available global research pool, "evidence" is still predominantly under an empirical hegemony in which quantitative research rules. Because of the history of exploitation of Africans by European colonisers, Africans are particularly critical and suspicious of the materialism imported by European settlers. Seghnor, a well-known Senegalese philosopher, maintains that this preoccupation with materialism makes a true understanding of the person and the truly human society impossible and that theoretical and practical materialism is "born of the application of scientific reason to every aspect of life".⁸

Visvanathan⁹ views western scientific research as an act of alienation and likens it to a pilgrimage:

"... pilgrimages usually begin in wonder, submission and faith, but modern science is a journey that began in doubt. In fact, doubt occupies in modern Western thought the same central position which wonder occupies in Greek thought. The history of Western thought has been a celebration of the victories of doubt over common sense. The histories of the Copernican, Darwinian and Freudian revolutions has been the triumphs of doubting man. It was the sciences way of seeing, the lenses and maps it constructed and placed between itself and the world that rewrote the world." (page 40)

It is these perspectives of the scientific self that he says need to be considered when comparing western thinking to that of other ways of thinking.

The difference between the way we conduct science in Africa and how science is conducted in the West lies within the social, economic, political and cultural context. What is most important is how the countries and people concerned benefit from the research produced. Modern science was introduced to Africa by the colonialists and was impoverished because of the lack of adequate analytical laboratory facilities. As a result, collected data was exported to laboratories of research in western countries for analysis (by people who had little, if any, insight into the unique context of Africa), thus the knowledge produced was deprived of the inner element or theory building activity that makes science.¹⁰

While the situation has changed today in terms of the research facilities available in South Africa, there is still what Hountondji¹⁰ described as a type of institutional nomadism in which African scholars migrate to western countries and strive to have their research publications printed in western journals for a western readership. One of the consequences of this is that scholars tend to address issues that are primarily of importance to the western public. As a result, issues of primary importance to an African readership are neglected.

In addition, researchers with a western bias who are exploring issues related to wellness and occupation in non-western cultures tend to translate the voices within their data into representations that are acceptable to public academic audiences. The voice of the "other" is thus undermined and cannot be heard by a public western audience except through the researcher as "interpreter"¹¹. The power and dominance inherent within such research poses a question as to its transportability to other cultures, and hence its reliability and validity as adequate evidence upon which to base decisions.

2. Availability of human resources and accessibility of resources

South Africa is a strange dichotomy in that it contains a mix of the "first" and "third" worlds. There is the public sector health care service which, particularly in the District Health Systems, is semi-rural and rural-based and serves populations of mostly disadvantaged African people. These people have access to fairly unsophisticated treatment by health professional teams who are hard-pushed to keep up with the large numbers requiring their attention. On the other hand, the private sector health care service, which is mostly urban-based, has all the sophisticated technology, skills, knowledge and intervention ability to compete with any similar service in the western world.

However, in comparison to countries such as Canada, New Zealand, the United States, the United Kingdom and Australia, where EBP is promoted, the ratio of therapist to patient in South Africa is considerably lower. In addition, access to resources such as the Internet and libraries may be relatively easy in most urban areas of South Africa, but is virtually non-existent or very difficult to access in many rural areas.

An added challenge for occupational therapy services is that they are heavily burdened with HIV/Aids sufferers and many complex multi-diagnostic cases. These, in turn, may be further complicated by socio-economic and other factors. The heavy patient load and the complexity of cases make it extremely difficult for the average occupational therapist to find the time to access all the various resources to obtain the necessary evidence required.

The heavy burden on health services in sub-Saharan Africa is described in the World Health Organisation's 2003 World Health Report¹²:

"Overall, 35% of Africa's children are at higher risk of death than they were 10 years ago. Every hour, more than 500 African mothers lose a small child. In 2002, more than four million African children died. Those who do make it past childhood are confronted with adult death rates that exceed those of 30 years ago. Life expectancy, always shorter here than almost anywhere else, is shrinking. In some African countries it has been cut by 20 years and life expectancy for men is less than 46 years.

"... HIV/Aids, now the world's leading cause of death in adults aged 15 – 59 years, is killing almost 5 000 men and women in this age group, and almost 1 000 of their children, every 24 hours in sub-Saharan Africa." (page 3)

Apart from the, until recently unknown, opportunistic infections and neuro-psychological conditions and complications that HIV/Aids may present with, the additional problems of loss of work, the affliction of multiple family mem-

bers, social stigma and isolation, are but a few of the consequences for someone with this complex of diseases. Occupational therapy departments in public sector hospitals in South Africa are being swamped with these cases, probably because doctors can do no more for them. Where does one begin to search for evidence to treat the multiplicity of problems presented by HIV/Aids?

3. What do we put our students through four years of in-depth, extensive study and practical work for?

Occupational therapy training in South Africa takes four very full-time years. We have been accused repeatedly of overloading our courses and putting considerable stress on our students as a result. Our graduates are recruited throughout the world and we have had good reports from recruiting agencies about the excellent quality of South African occupational therapists. Why, then, when one has spent four intensive years studying to become an occupational therapist, should it be necessary thereafter to continuously be looking for evidence to determine if what one is doing is correct or not? There is a sense that the concept and process of EBP questions not only the integrity of the training we provide for our students but also the enormous wealth of experience with its tried-and-tested methods, skills and techniques that have been perfected over decades.

In addition, occupational therapy training in South Africa places considerable emphasis on the holistic biopsychosocial and spiritual nature of mankind and the complex implications of physical or psychiatric disability upon the individual's ability to participate in occupations of all kinds. As a result, it would be not only difficult but contrary to our ethos to change the undergraduate education of occupational therapists to one that follows a problem-solving approach based upon extrapolations from a largely empirical, reductionistic and totally western world view.

This does not mean that we should not be constantly updating and reviewing our knowledge base. Obviously, we would be extremely naïve, foolish and arrogant to think that we need not constantly scan our national and global environments for appropriate, new and successful discoveries in the multiple directions our profession leads us. It is the method of doing this that I question.

4. Research

This is the area of most concern. The following points are of particular relevance to this paper:

4.1. Availability

South African occupational therapists are particularly bad at producing research. Given our profession's multiple foci in terms of our holistic approach and the complexity of human occupation, it is indeed doubtful that, even if all of us undertook a research project immediately, we would ever cover the enormity of areas that require researching within our profession. Obviously, our sources should not only include evidence from occupational therapy researchers, but this is the most desirable route.

Rappolt¹³ maintains that the shortage of creditable research is one of four main limitations to EBP. She also maintains that there is, to date, very little research evidence to support the fact that EBP actually works and that *"implicit in the promotion of evidence-based practice is the notion that high-quality evidence is available to address each clinical question."* She goes on to state that the shortage of coherent and consistent scientific evidence in occupational therapy is

compounded by the failure to develop systematic methods of applying the results of qualitative research within clinical decision making. Rappolt thus advises that the professional expertise of occupational therapists in collaboration with that of the client's evidence should further inform the existing evidence.

4.2. Quantitative versus qualitative research

Another concern is that EBP is so centred on quantitative research. It seems fairly obvious that the reason for this is that EBP is ideologically rooted within the positivistic, and very reductionistic, medical model. In this model the results of quantitative research are considered superior in value to those of qualitative research. If this were not the case, qualitative research would not be placed so low down on the hierarchy (refer back to Table I)

Speculating the merits of one paradigm against the other is senseless in view of the type of evidence sought, and the fact that often a combination of paradigms provides the best evidence. It is the sovereignty that quantitative research is given over the other, that concerns me. Cusick¹⁴ maintains that the present emphasis on quantitative research in EBP could well influence what we become as a profession in the future.

Perhaps the best way to describe concern about the demotion of qualitative research is expressed by the French philosopher Michel Foucault who, when discussing the manner in which society exerts power over the knowledge we may, or may not possess, maintained that:

"... it is not that the beautiful totality of the individual is amputated, repressed, altered by our social order, it is rather that the individual is carefully fabricated within it, according to a whole technique of forces and bodies." (p66)¹⁵

How is it possible, considering the exceptional complexity of psyche, soma, spirit and context that constitute the human as occupational being, to reduce our search for evidence mainly to quantifiable factors? The EBP experts will argue that there is now a growing bank of qualitative evidence on the Internet; however, existing journals tend to be biased in favour of quantitative research methods.

Research close to the positivist end of the continuum has been and still is highly criticised by the disability sector, which, after all, is occupational therapists' main source of research subjects. Barnes and Mercer¹⁶ explain that in mainstream research the relationship between the researcher and the researched is asymmetrically biased in favour of the researcher and is therefore the main reason for the alienation of disabled people from the research process. Where are the voices of those we research within the quantitative models held in such high esteem in EBP?

Modernday social models tend towards the use of critical theory with its emancipatory and openly partisan approach to matters concerning people with disabilities¹⁶. *"Emancipatory research is about the systematic demystification of the very structures and processes which create disability."* (p120) Surely this is the sort of research we should hold in higher esteem than the kind that is often responsible for the mystification of the structures and processes that create disability?

In addition, when discussing Foucault's thesis on power, McHoul & Grace¹⁵ highlight the essential link between power relations and their capacity to produce the "truths" we live by. They maintain that in many western societies truth is

seen as the product of science or scientific method and, thus, while it is possible to be sceptical of science, it is much more difficult to question why science is held in such high esteem. Foucault's concern of the modern patient as an object in medicine was counterparted by his belief in the importance of the knowledge the subject has of himself or herself,¹⁵ knowledge which should and must be used in the type of research we do as occupational therapists.

What motivates the theory – money or concern for the client?

The whole process leading up to and driving the almost fanatical continuity of EBP may have part of its origins in materialistic motivations. In fact, it has virtually become an industry. For example, there are the dogmatic formulae that managed health care systems impose on their employees to follow carefully worked-out recipes based on the evidence in order to get the high-paying patients moved on as quickly as possible so as to make way for more.

There is also an enormous number of websites, resource centres and other research stakeholders who exploit the process for financial reasons. At the end of the day, who is gaining from the process, the service or the patient?

Another concern related to materialism is the enormous sponsorship that various drug and other medical supply companies provide for research. These stakeholders have different interests and agendas. The asymmetrical bias in favour of the researcher also results in a few key funding bodies controlling the research that is undertaken and researcher experts control the design, implementation and dissemination, resulting in the "subjects", or more appropriately the "objects", of research having little if any positive input and no sense of ownership of the research process.¹⁶

One cannot help but speculate what influence it may have upon the effect on the outcomes of research studies when they are sponsored by a pharmaceutical or medical supply company that has a vested interest in the outcome.

How can we ensure accountability and quality assurance without going to extremes?

- It is an imperative that we as South African occupational therapists regularly and seriously follow existing research, both globally and locally, that is applicable to the treatment interventions and trends in occupational therapy and related fields of service.
- We need to monitor cases not improving on conventional treatment methods and if these do not show results, then EBP principles must be applied. This thus becomes more selective and less time consuming.
- We must continuously assess our clients throughout treatment to be assured they are responding to the treatment.
- We must carry out more South African context-specific research and publish and write up articles for our colleagues when we have had success in various interventions and applications.
- We should consult the experts who have years of experience in treatment and who have intuitive feelings about what is right and wrong. They can provide a wealth of knowledge, despite the fact that it is not written up.
- Collaborative work with our client's and caregivers as to what works well with them reinforces our knowledge base
- The Health Professions Council of South Africa's new legislation on Continuing Professional Development is also a method of assuring that therapists continue to update their knowledge

Conclusions

I want to make it clear that I am not trying to demonise EBP, I believe it is gradually coming into its own and will hopefully become refined enough to make it suitable for our context. I am simply trying to evoke a critical regard for it from South African therapists. Of course, we need to be accountable and in many, but not all, instances "scientific" about what we do and how we do it. But there is much more to occupational therapy than the generally restrictive empirical view by which EBP seems to be largely influenced.

We are no longer fledglings who need to depend upon the constant approval and support of our western colleagues, nor do we need to swallow, hook, line and sinker, everything they tell us. We have a collective knowledge that has served us for decades, thus, we do not need to question everything we do. We are not called the rainbow nation for nothing, we have large reserves of creativity, we are continuously exposed to hugely challenging experiential learning situations, unlike many occupational therapists globally, and it's time we acknowledged this.

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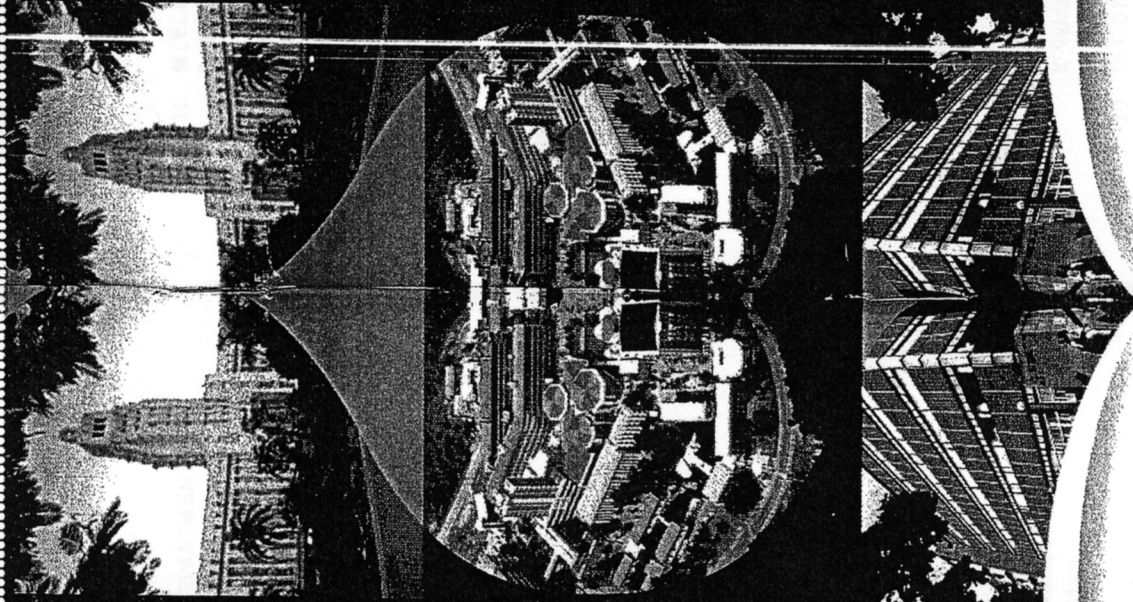
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UNIVERSITY OF
KWAZULU-NATAL



Astrazeneca College of Health Sciences Research Symposium

Wednesday 28 & Thursday 29
September 2005

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09H15 LEARNING TO LEARN: MEDICAL STUDENTS' CONCEPTIONS OF LEARNING
S Singaram, School of Undergraduate Medical Education

09H25 A WORK IN PROGRESS: "CITRUS CLOUDS ON PLANET GOOFY": THE LIVED EXPERIENCES OF CHILDREN WITH LEARNING DISABILITIES
PS Flack, Discipline of Speech-Language Pathology

09H35 DEALING WITH SUDDEN DEATH IN EMERGENCY DEPARTMENTS
P Brysiewicz, School of Nursing

09H45 TEA

SESSION III
CHAIRPERSON: PROF J BOTHA

10H10 AN EVALUATION OF POSTPRANDIAL GLUCOSE EXCURSIONS IN TYPE 2 DIABETIC MELLITUS PATIENTS ON MONOTARD[®] HM (GE) (M) VERSUS HUMULIN (HN) OR HUMULIN L[®] INSULIN, EACH IN COMBINATION OF METFORMIN
N Singh, Discipline of Pharmacology

10H20 AN EVALUATION OF THE PRESCRIBING PATTERN OF HORMONE THERAPY IN THE ETHEKWINI AREA (POST WHI)
S Simjee, Discipline of Pharmacology

10H30 IDENTIFICATION OF RISK FACTORS IMPLICATED IN DIABETIC KETOACIDOSIS (DKA) IN TYPE 2 DIABETES MELLITUS
S Mudly, Discipline of Pharmacology

10H40 PHARMACOKINETIC-PHARMACODYNAMIC MODELING OF GLIBENCLAMIDE
V Rambiritch, Discipline of Pharmacology

10H50 THE EFFECT OF GLICLAZIDE ON POSTPRANDIAL HYPERGLYCAEMIA
P Naidoo, Discipline of Pharmacology

11H00 ENTERTAINMENT
INAUGURATION OF THE CHANCELLOR & VICE-CHANCELLOR Examination Hall, 6th Floor, Main Medical School Building

12H00 LUNCH

SESSION IV
CHAIRPERSON: PROF P MCINERNEY

13H05 COMMUNITY IMPACT OF HIV DISCLOSURE BY PLWHAS THROUGH AN INTEGRATED COMMUNITY HOME-BASED CARE (ICHC) PROGRAMME
B Ncama, School of Nursing

13H15 MSELENI JOINT DISEASE
S Mabude, Department of Pathology

13H25 INDIGENOUS FRUITS FROM EXOTIC ROOTS? REVISITING THE SOUTH AFRICAN OCCUPATIONAL THERAPY CURRICULUM
R Joubert, Discipline of Occupational Therapy

13H35 A RETROSPECTIVE ANALYSIS AND EVALUATION OF THE ROLE OF GASTROSCOPY IN PATIENTS WHO HAVE APPROVED GASTRO- OESOPHAGEAL REFLUX DISEASE (GORD) FROM A PRIVATE MEDICAL AID FUND
AB Suleman, Discipline of Pharmacology

SESSION V
CHAIRPERSON: DR K MLISANA

13H50 AN EVALUATION OF THE CURRENT PSYCHOSOCIAL REHABILITATION SERVICES IN THE CHATSWORTH COMMUNITY
JR Naidoo, School of Nursing

14H00 THE IMMUNOTOXIC EFFECTS OF FUMONISIN B1 AND ZEAREALANONE IN HUMAN LYMPHOCYTES
RE Myburg, Discipline of Medical Biochemistry

14H10 AN INVESTIGATION OF LYMPHOCYTE APOPTOSIS IN BLACK SOUTH AFRICAN RHEUMATOID ARTHRITIS PATIENTS - A PRELIMINARY STUDY
D Woodley, Discipline of Medical Biochemistry

14H20 AFE FUMONISINS INVOLVED IN THE AETIOLOGY OF OESOPHAGEAL CARCINOMA IN SOUTH AFRICA?
K Vaidoo, Discipline of Medical Biochemistry

14H30 THE DEVELOPMENT AND PRELIMINARY CHARACTERIZATION OF NOVEL CALCIUM ALGINATE BASED MICROSPHERES CONTAINING METRONIDAZOLE
T Moodley, School of Pharmacy & Pharmacology



ABSTRACT BOOK & CONGRESS PROGRAM

of the

30TH NATIONAL CONGRESS

presented by the

OCCUPATIONAL THERAPY ASSOCIATION

OF SOUTH AFRICA

Cape Town

3 – 5 May 2004

ORAL PRESENTATIONS : SESSION 1 : Tuesday 4 May : North venue**Discussant : Madri Engelbrecht**

08h45 – 09h00	Homelessness viewed through the Person Environment Occupation Model and the lived experience Sharon Brintnell (Canada)
09h00 – 09h15	Understanding the lived experience of occupational deprivation : A refugee case example Gail Whiteford (Australia)
09h15 – 09h30	Transcultural occupation and transcultural occupational therapy – emerging phenomena Zelda Coetzee
09h30 – 09h45	Challenging the human 'being' not only the human body : The experience of engaging in the occupation of horse riding for adults with physical disabilities Carmella Barron, Megan Harrison & Jean Mockford
09h45 – 10h00	Occupational adaptation in the workplace to reduce stress Claire Henshall
10h00 – 10h25	DISCUSSION: Presenters and Discussant interact with the audience

ORAL PRESENTATIONS : SESSION 2 : Tuesday 4 May : North venue**Discussant : Elelwani Ramugondo**

11h00 – 11h15	Developing innovative occupational therapy practice ✓ Roshan Galvaan
11h15 – 11h30	The story behind the research: Issues for the practitioner ✓ Gudrun van Heukelum
11h30 – 11h45	Evidence Based Practice – does it work for the South African context? *
11h45 – 12h00	Occupational Therapists – businesswomen of the future? Lisha Chetty
12h00 – 12h15	How ideology theory can empower OT's for the future Tania van der Merwe
12h15 – 12h40	DISCUSSION: Presenters and Discussant interact with the audience

ORAL PRESENTATIONS : SESSION 3 : Tuesday 4 May : North venue**Discussant : Lethie Lester**

14h00 – 14h15	Organizing assessment data – The Occupational Performance Profile Sharon Brintnell (Canada)
14h15 – 14h30	The ergonomic model in occupational therapy Franklin Stein (USA)
14h30 – 14h45	In a manner of speaking Maureen Casey
14h45 – 15h00	Challenges to enhancing the human potential of deaf people Meryl Glaser & Theresa Lorenzo
15h00 – 15h15	Occupational Therapy for all by 2010 Pat de Witt
15h15 – 15h40	DISCUSSION: Presenters and Discussant interact with the audience

ORAL PRESENTATIONS : SESSION 4 : Tuesday 4 May : North venue**Discussant : Lana van Niekerk**

16h00 – 16h15	CBR – Making inclusion possible Rose Mashaba & Jabulile Zitha
16h15 – 16h30	Social skills training with community based rehabilitation consultants in Mpumalanga province Jennie McAdam
16h30 – 16h45	Occupational Therapy Ke Eng? Perspectives on occupational therapy's role and function from rural health workers Bronwen Stewart
16h45 – 17h00	An Occupational Therapy response to the public health issue of diet and nutrition in developing communities Michelle Janse van Rensburg
17h00 – 17h15	Hungry children cannot learn Edith Muller
17h15 – 17h40	DISCUSSION : Presenters and Discussant interact with the audience



OTARG CONGRESS 2005

OT in Africa: in search of identity



**The 4th Congress
of the Occupational
Therapy African
Regional Group**



Uhuru Conference Centre, Moshi, Tanzania
15th – 19th August 2005

PROGRAMME

FULL CONFERENCE TIMETABLE

MONDAY 15 AUGUST

08:00 – 09:30 **Registration**

09:30 – 10:00 *Tea/coffee*

10:00 – 12:30

OFFICIAL OPENING OF THE CONGRESS

Welcome: Mr Dani Swai, Chairman of the Congress

Greetings & introduction by Mr Harold Shangali,
Dean, Faculty of Rehabilitation Medicine, Kilimanjaro Christian Medical College

Opening prayer

Welcome addresses:

Objectives & vision of OTARG **Dr Rosemary Crouch, OTARG**

Government development of training in Tanzania **Dr Gilbert Mliga,**
Director of Human Resource Development

Establishment of OT training in Moshi and its future **Professor John Shao, KCMC**

Current issues facing WFOT and OT in Africa **Professor Sharon Brintnell, WFOT**

Entertainment: video on Tanzanian culture, introduced by Herma Grossmann

12:30 – 14:00

Lunch

14:00 – 17:00

EDUCATION SEMINAR

Chairman: Mr Alfred Ramukumba,
University of Limpopo, Pretoria, South Africa

Keynote Speaker: Ms Robin Joubert,
University of Kwazulu Natal, South Africa

19:00 – 22:00

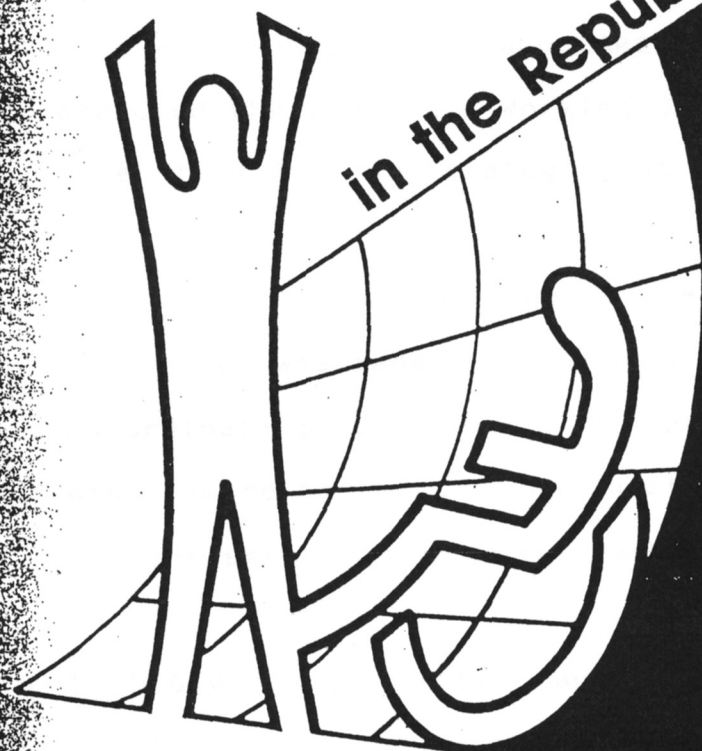
Welcome reception, Sal Salinero Lodge

Traditional Tanzanian evening with dancing & live music

APPENDIX G

Lists of members for Working groups: Prevention and Treatment Year of Disabled 1986

DISABILITY in the Republic of South Africa



Prevention
Volume 2

CO-ORDINATION COMMITTEE: Year of Disabled Persons 1986
Department of National Health and Population Development

NOVEMBER 1987



As a result, research was done in various fields and the research reports were submitted to the

Co-ordinating Committee, who decided to appoint four MAIN WORKING COMMITTEES. They were directed to compile integrated reports on the basis of the research reports of the subcommittees and working committees with regard to the four main areas of disabled care namely PREVENTION, TREATMENT, DEVELOPMENT AND CARE. The Co-ordinating Committee directed the four Main Working Committees to formulate general policy and strategies at the macro level.

The Main Working Committee on the Care of the Disabled and Prevention was made up of people who, in the opinion of the Co-ordinating Committee, have special knowledge or expertise with regard to the prevention of disability. The following persons served on the Main Working Committee:

- ✕ Dr H.G.V. Küstner (Chairman) Department of National Health and Population Development
- ✓ Prof W. Bodemer University of Pretoria
- Mr M.S. Bornman Administration: House of Assembly
- Mrs D. Charlesworth Department of National Health and Population Development ✕

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✓ Prof. M. Joubert

✗ Dr M. Langton

Adv. B.J. Malatji

Mr B. Matthysen

✗ Dr G. Oberholster

✗ Dr J. Op't Hof

Brig. E.O. Prinsloo

✓ Prof. A.D. Rothberg

✗ Dr F.C.A. Smith

✓ Prof. W.F. van Delft

Mr S.J. van der Walt

Miss A.M. Bredell

Secretary

Medical University of
Southern Africa

Medical Bureau for
Occupational Diseases
Disabled People South
Africa

National Occupational
Safety Association

Department of National
Health and Population
Development

Department of National
Health and Population
Development

S.A. Defence Force
University of the
Witwatersrand

University of Pretoria
University of South
Africa

Bureau for the Prevention
of Blindness

Department of National
Health and Population
Development

DISABILITY in the Republic of South Africa



Treatment
Volume 3

CO-ORDINATION COMMITTEE: Year of Disabled Persons 1986
Department of National Health and Population Development
NOVEMBER 1987



CHAPTER 1

GENERAL

1.1 DIRECTIVE AND METHOD FOLLOWED

The Co-ordinating Committee of the Year of Disabled People, 1986, considered it necessary to constitute a Main Working Committee with instructions to write a report on the treatment of disabled people. According to the terms of reference, the reports of the subcommittees and working committees had to be reviewed and all information on treatment contained therein, as well as other relevant information, had to be summarised in this report. The further task of the Main Working Committee was to assimilate the information in such a way that policy guide-lines and strategies could be developed.

The following people served on the Main Working Committee:

Chairman:

Prof. C.L. Wicht	Head of Department Community Health, Tygerberg Hospital
------------------	--

Dr W.S. Lampen	Hospital Services, TPA
----------------	------------------------

Dr A. Key	Orthopaedic surgeon
-----------	---------------------

Mrs A. Mathias	Chief Physiotherapist Johannesburg Hospital
----------------	--

Prof. J.C. de Villiers	Head of Department of Neurosurgery, University of Cape Town
------------------------	--

Miss K. Jagoe	Programme Organiser: "Disabled Students' Programme", University of the Witwatersrand
---------------	--

Dr P.S. Maharasj	Department of Health Services and Welfare, Administration: House of Delegates
Mr S.W. Broderick	Department of Health Services and Welfare, Administration: House of Representatives
Mr M. du Toit	Disabled People S.A. p15
Dr H. Robertson	Department of Health Services and Welfare, Administration: House of Representatives
Mr L. Zandberg	Nursing Services, Department of National Health and Population Development
Prof. J.J.F. Taljaard	Head of Department of Chemical Pathology, Tygerberg Hospital
Dr H. Steyn	Department of Health Services and Welfare, Administration: House of Representatives
Prof. T. Malan	Department of Orthopaedics, MEDUNSA
Dr A. Levin	Mental Health, Department of Health Services and Welfare, Administration: House of Assembly
Prof. G.F. Domisse	Department of Orthopaedics, H.F. Verwoerd Hospital
Dr R. Golele	Department of Orthopaedics, MEDUNSA
Dr Potgieter	Department of Pediatrics, MEDUNSA

Dr J.B. Davies

Ernest Oppenheimer Hospital, Welkom
(Chamber of Mines)

The members of the editorial committee,

Dr J.F.J. Hattingh, Mr E.W. Harvey, Mr J.N.P. Saayman and
Ms M. van Jaarsveldt, attended all the meetings of the Main
Working Committee.

The following method was used to compile the report:

The Main Working Committee discussed procedures in order to
rationalise the format of the report on Treatment.

The members of the Main Working Committee provided expert
guide-lines on all matters related to the treatment of
disability. The reports of the various subcommittees and working
committees were classified according to the disciplines
involved. The individual reports on the treatment of the various
disabilities were then reviewed by the various experts in order
to formulate guide-lines.

Attention was given to the following: the incidence of the
disability in question in the RSA; its incidence according to
development region classification (depending on the availability
of data); situation analysis in terms of certain norms regarding
existing treatment services for the early identification of
sub-clinical illness; treatment services for illness that can be
identified at an early stage and for advanced illness and for
illness with permanent disability; the identification of
shortcomings; the formulation of objectives; and a policy and
strategies for the implementation of the policy in accordance
with the guide-lines and objectives.

After reading and working through the various subcommittee and
working committee reports and introducing their own views and
opinions, the members of the Main Working Committee drafted their
own report, all reports were checked by the Chairman and the

APPENDIX H

**Analysed package of SAQA submissions and focus groups
which was sent out to resonance group members.**

RESONANCE GROUP MEMBERS,

12 April 2004-04-12

Dear Colleagues,

RESEARCH FOR DOCTORAL THESIS.

You will hopefully recall our various meetings and focus groups in which most of you participated to assist me in gathering much needed data for my D.Ed degree. Well, as is common with research deadlines, it has taken me much longer to gather and analyse my data than I expected and hence the considerable delay in getting this out to you all. As a consequence of this delay I expect many of you have understandably forgotten what my research is all about and what your role in assisting me with it is. So indulge me while I briefly run you through it.

My research is particularly concerned with the fact that, for many reasons which will become apparent in the attachments, our profession and role is rapidly changing and we are not keeping adequately abreast of these changes. As a point of departure I have decided to explore the current methods used in training centers to assess the final competencies of students about to graduate to see if these are assessing what they should be assessing.

In order to do this:

- I have analysed all the OT training centers submissions to SAQA to try and compile a profile of competencies expected of graduating occupational therapists in South Africa (See Annexure 1- Attachment)
- I have held 4 focus groups around the country which included clinicians and lecturers to try and obtain their views around relevant issues, the summary of analysis of these groups is to be found in Annexure 2 – Attachment.

Now this is where your part comes in, I have referred to you as my resonance group members, because I intend to bounce off you the views and opinions which develop and evolve out of my data analysis. I do realise you are always busy and this is quite a demanding task and thus again wish to express my understanding should you need to withdraw from the group. However I think you will actually find the information forthcoming to be quite interesting and hopefully easy to read.

What I would like you to do is the following:

Read carefully through the two annexures attached jotting down comments, criticisms, concerns, ideas which may come to mind as you do so. Then answer the following questions:

- 1) Do you think the information obtained in Annexure 1, adequately represents the final competencies required of a graduating OT? Please qualify your reasons for agreement or disagreement.
- 2) Bearing in mind the types of methods you are acquainted with which are used in assessing final competencies of graduating OTs (eg. Case studies, written tests/exams/OSPEs etc) , do you think they would be able to adequately assess all the competencies listed in this document (Annexure 1) Please motivate your response and if applicable provide examples of other methods of assessment not commonly used today.
- 3) Do you think the findings of the analysis of focus groups expressed in Annexure 2 are a realistic reflection of where OT is in South Africa today? Please motivate your answer.
- 4) What do you think constitutes professionalism in occupational therapy?
- 5) Please also add any additional comments or views that may have arisen for you whilst reading these documents.

I have emailed these as it is much quicker to do so electronically. However it will require that you print out approximately 22 pages, thus if you would rather that I sent you copies in the post please notify me immediately with your postal address.

May I end in expressing my most sincere gratitude to you in anticipation of your participation in this research. I do believe it will give birth to some very relevant information for our profession and thus really look forward to your responses. It goes without saying that your overall input will be acknowledged in the final research however if there any specific information about which you wish to either remain anonymous or have specific acknowledgment, please indicate this to me in your response.

I will be taking study leave from June through to the end of September 2004 and thus would like to complete the analysis of your responses by the end June 2004, which would mean I need your responses by 15th June 2004. This gives you approximately 6 weeks. I hope this is not asking too much of you? You can contact me on 031-2622658 (home) 031-2607953(B) or 0834821799 or email me if you have any queries or problems.

Kind regards

Robin Joubert

A PROFILE OF FINAL COMPETENCIES EXPECTED OF A GRADUATING OCCUPATIONAL THERAPIST IN SOUTH AFRICA.

Robin Joubert. July 2003. (As part of data for D.Ed degree.)

1. Introduction:

This profile was compiled as part of the process of data gathering and analysis for a Doctoral Thesis in which the researcher questions the current methods of assessing final competencies in final year students. The purpose of compiling this profile is to be able to have a discussion documented around and from which critique can be evoked to determine whether existing methods of measuring terminal competencies (particularly the case study) are adequate. Please note that those sections in italics are those included by the researcher where she felt there was a serious deficit in the information submitted.

2. Method:

- 2.1. **Sample:** All eight departments at Universities in South Africa, training occupational therapists. They are: the Universities of Cape Town, Durban-Westville, Free State, MEDUNSA, Pretoria, Stellenbosch, Western Cape and Witwatersrand hereafter referred to as the *training centers*.
- 2.2. **Data gathering:** All eight training centers were requested to submit to the researcher copies of the submissions they made to the South African Qualifications Authority (SAQA) for registration of their various degrees, hereinafter referred to as the SAQA submissions. In these documents each training center defines what it maintains are the terminal competencies of graduating occupational therapists and it was therefore deemed an excellent starting point and source from which to try and compile a collective profile of these terminal competencies.

All eight training centers responded timeously in submitting their SAQA Submissions.

- 2.3. **Data analysis:** A qualitative approach using grounded theory was applied. The researcher was particularly concerned in retaining the rich diversity of current practice espoused in the documents and thus the approach used was specifically concerned with overcoming the risk of analysis becoming too sanitised by overly rigid methodological prescription. Strauss & Corbin in Richardson (1996).

Thus in trying to reduce competency themes (outcomes) to a single coherent interpretation of the many ideas contributing towards them it is possible that some aspects of these competencies may have been lost in the process, it is hoped this error was minimal or that aspects lost in one category of competencies may emerge in another according to the researchers specific interpretation as will be discussed below.

Method:

Repeated reading of the documents to try and establish common threads, themes and categories. As the documents were compiled according to a specific template suggested by the National Qualifications Framework. The categories suggested by SAQA for writing up the learning categories were used by the researcher as common thematic areas. They are: knowledge and understanding (knowing why); skills and competencies (knowing how) and attitudes and values (held by graduating student).

3. Operational definitions

3.1. Introduction:

In order to ensure uniformity of understanding in the reading of this document it is integral that the reader has a clear understanding of the concepts as they have been operationalised to the context of occupational therapy training and this particular research.

3.1.1. **Knowledge:** refers to the essential, foundational, theoretical knowledge required by the qualifying occupational therapist in order to both appreciate and understand the human as an occupational being as well as the environmental and biopsychosocial factors which impact upon the ability to function as an occupational being.

3.1.2. **Skills and abilities:** although these two words have similar connotations and meanings in that they denote the capacity to perform certain acts and functions successfully and with proficiency, in the context of this document their fundamental differences must be noted in order to appreciate the decision of the author to place some competencies under one category and some under the other. It should also be noted that these two concepts cannot be separated because they are, for the most part, an integrated whole.

- **Skill:** refers to the *acquired* capacity to successfully accomplish something which requires the use or application of specialised knowledge and /or technique and /or tools and equipment and/or tests. For example the use of a goniometer to test ROM or the application of Neurodevelopmental techniques.
- **Ability:** refers to a combination of *innate* and *acquired* capabilities which enhance the occupational therapists capacity to perform certain therapeutic acts and/or procedures optimally. For example the ability to communicate with and handle the patient in an optimally therapeutic manner, the ability to be innovative or use creative thought in designing a treatment programme.

3.1.3. **Attitudes and values:** These two concepts also have similarities in that they imply a subjective state of mind or disposition towards certain behavioural standards, beliefs and/or principles. Both are influenced by the individuals unique set of cultural, religious, socio-economic and environmental circumstances.

Because they are evolving and dynamic concepts both can be influenced and molded by the particular ethos of the training center in which the student occupational therapist finds him/herself.

- **Attitudes:** refers to the nurturing of opinions, behaviours and dispositions within the occupational therapy trainee which will provide him/her with the ability to respect the uniqueness of each client and positively influence the progress of all persons assigned to his/her care. E.g. an appreciation for and implementation of ethical professional behaviour and respect for cultural diversity.
- **Values:** refers to the nurturing of standards, principles, convictions and/or qualities which are regarded by occupational therapists as desirable in a professional committed to the restoration of occupational function in individuals suffering from conditions which may impact negatively upon occupational function. For example those values enshrined in the code of ethics.

4. Profile of terminal competencies.

4.1. Knowledge: On qualification the student will:

- 1) Be able to competently analyse, integrate, synthesise and apply the appropriate fundamental and specialist knowledge about a wide diversity of relevant medical, social and occupational sciences and theoretical constructs which include:
 - a holistic view of the biopsychosocial and environmental components which promote or impede human occupation.
 - The knowledge of how to assess biopsychosocial, environmental and occupational components which either promote or impede the adequate performance of human occupation and concomitantly also the well-being and quality of life of individuals, groups or communities with occupational dysfunction or at risk of acquiring occupational dysfunction.
 - How the social, medical and occupational sub-systems inter-relate and a sound understanding of the various models of health care as a basis for client evaluation and intervention strategies.
 - An understanding of how (*relevant*) legislation, policies and ethics influence occupational therapy practice.
- 2) Understand the steps necessary to identify a research problem, decide on an appropriate research paradigm, select the correct method of implementing the research and report on the findings of the research.
- 3) Have a basic knowledge of appropriate technology and how to use it effectively, critically and responsibly..
- 4) Be able to use the professional knowledge base of treatment and professional support structures for developing occupational therapy protocols for client populations within the health, educational, welfare and private services.

- 5) Have an understanding of basic management and administrative principles which will provide the graduate with the ability to adequately manage his/her own time and the administrative tasks required of the service/practice within which he/she will work.

4.2. **Skills and Abilities:** On qualification the student will:

- 1) be able to work effectively with others as a member of a team, group, organisation or community within a multi, inter or transdisciplinary context depending on the specific situation within which s/he works.
- 2) Be able to communicate effectively:
 - using verbal and non-verbal skills as well as
 - audio-visual methods in oral, diagrammatic and written presentation form.
 - be able to listen to and interpret with acuity, sensitivity and discernment what is being said at all levels of communication

This communication occurs:

- on a professional level with members of the team, group, organisation or community in which s/he may work
 - on a therapeutic, facilitatory level with clients, groups of clients and/or their caregivers,.
 - *with resource persons such as employers, suppliers etc.*
- 3) Be able to apply appropriate standardised and non-standardised **assessment** methods and techniques as follows:
 - To individuals in order to collect data about factors related to their physiological, psychosocial, occupational and environmental status. This information will provide the therapist with a holistic picture of the client's needs, strengths and priorities and as such form the basis upon which appropriate treatment intervention programmes are planned and implemented.
 - Small groups: in order to assess common needs and priorities
 - Be able to screen large numbers of individuals or communities in order to determine the impact of disability upon the occupational performance of affected members within the group/community and determine which of these members require further assessment and/or determine which members of the group/community may require *promotive* or preventative programme intervention to avoid occupational dysfunction.
 - 4) Be able to carry out a **situational analysis** within a variety of contexts in order to plan effective intervention programmes for client groups identified in various institutions, facilities, services and organisations.
 8. Be able to effectively **record, analyse, interpret and prioritise data** gathered from all situation described in 3 and 4 above and as a result of

these findings be able to compile and **plan aims and objectives for intervention.**

6) Based on analysis of data gathered in 3,4 and 5 above be able to:

6.1. plan, develop, design and implement integrated **treatment programmes** for:

- Individuals or groups of individuals
- Any form of physical and/or psychiatric disorder which results in occupational dysfunction
- Short-term, medium-term and long-term durational requirements
- Institutional, hospital, health services and ward, clinic and/or community contexts in a *primary health care and district health services setting*.
- Preventive, promotive, curative, habilitative and rehabilitative contexts.

6.2. Apply the appropriate therapeutic skills, knowledge and principles for:

- activity analysis, selection, structuring, presentation, client handling and precautionary measures within any of the above programme contexts and within the unique socio-cultural and idiosyncratic context of the client.
- Be able to apply certain specialised techniques and/or make use of specialised equipment to enhance treatment and occupational performance (original version see new one above)

6.3. Throughout the implementation of the above treatment programmes to be able to integrate and apply and adapt the appropriate tools, skills, methods, techniques and principles in order to facilitate optimal occupational performance of the client or groups of clients participating in the programme.

6.4. be able to identify, **access and utilise appropriate human and material resources** within the specific treatment or home environment of the client or group of clients *and caregivers* and teach/ empower to be able to independently access and utilise these resources.

6.5. be able to **continuously evaluate** the effectiveness of own and other interventions against expected outcomes in order to modify, grade, continue or terminate intervention.

7. Be able to apply the following **management principles**:

- organise and manage him/herself and his/her time, daily activities, work environment, stress, and resources responsibly and effectively.
- delegate to, facilitate and guide the work of support staff and illicit their assistance in implementing the various treatment programmes.
- Develop protocols for patient populations using professional information bases
- Record, analyse and organise information/data effectively and perform the necessary administrative tasks essential in the management of client treatment or programme implementation and service/departmental management.

- Interpret and act appropriately on referrals and be able to refer clients appropriately when necessary
8. Able to carry out the following activities related to research:
- identify practice areas requiring research
 - select, plan and implement the appropriate quantitative and/or qualitative methodology
 - collect, organise analyse and critically evaluate data *and/or illicit appropriate expertise when/where necessary*
 - collaborate in research activities and/or projects where there is more than one researcher
 - access appropriate funding and resources with which to implement research projects.

4.3. Attitudes and values:

Attitudes:

On graduation the therapist will:

- Appreciate and respect the parameters and display the behaviours and responsibilities which mark professionalism
- Ethically evaluate occupational therapy practice and exhibit sensitivity towards the rights of others and their protection
Demonstrate sensitivity *and respect* across all cultural contexts and an innate empathy (*sympathy*) and understanding of the debilitating nature of *trauma* and disease
Be able to react as a responsible citizen in demonstrating an awareness of the ethical issues surrounding practice and a sensitivity towards the rights of clients at all times.
- Not to recoil from questioning dogma
- Be open towards the exercise of self criticism and the assimilation of critique.
- Understand the value of adherence to professional ethics in his/her practice.
- To be continuously and maximally employed in and to take responsibility for his/her own development.
- Work with responsibility towards and sensitivity to the social and environmental contexts of the client.
- Adhere to the professions code of conduct, ethical rules of the professional council and using disability, educational and employment legislation to the benefit of people with disability.

Values:

- Assign value to and apply human occupation as the primary means of achieving health objectives and as the primary end in promoting well-being and quality of life for individuals, groups and communities.
- Understand and respect the need for lifelong learning and be able to put this into practice through appropriate opportunities for continuing professional education (*development*).
- Respect and always consider the cultural values of the client in the selection of occupations/activities
- Show an awareness of the scope of the profession in order to be able to explore career and educational opportunities
- Demonstrate an understanding of the possible career choices available to an occupational therapist
- Demonstrate a positive attitude towards the need for professional research and the role of the occupational therapist in it.

DRAFT:

ANNEXURE 2.

SUMMARY OF ANALYSIS OF FOCUS GROUPS:

Robin Joubert (April 2004) Phase 4 of data analysis for D.Ed Degree University of KwaZulu-Natal.

Four focus groups were held consisting of a mix of clinicians and lecturers from Gauteng (X2 Johannesburg and Pretoria areas), Free State and KwaZulu-Natal

Four Questions were asked of each group as follows:

- 1) Do you think there have been changes in the role and scope of occupational therapy over the past 20 years?
- 2) Do you believe the demands in clinical reasoning and clinical competence have changed over the past 20 years?
- 3) Do you think that as OTs in Africa we have something unique to offer the rest of the world?
- 4) Do you think that the current methods used in the occupational therapy training centers that you are involved in, adequately assess the final competencies required of a student graduating as an occupational therapist?

The following is a summary of the responses, I have not given examples of some of the comments as with these the document would have consisted of some 30 odd pages which together with the SAQA analysis would have been far too much data to expect resonance group members to plough through.

ANALYSIS OF FOCUS GROUP'S RESPONSES TO QUESTION 1:

" Do you think there have been changes in the role and scope of occupational therapy over the past 20 years?"

1. **THE "OLD" VERSUS THE "NEW/YOUNG" OTS PERCEPTIONS.** There are conflicts evident between old and entrenched perceptions of what the role and scope of OT should be and strongly influenced by the past as opposed to the multiple new demands and challenges upon OT of today with their concomitant need for development of new approaches, attitudes, values, skills and knowledge. The "old" role and scope appears to have become so entrenched that even the old, and presumably wise, as well as some of the young and modern therapists are hesitant in totally committing themselves to the reality that it (role and scope) has changed and must continue to transform radically to meet the changing ethos of South Africa
2. **OCCUPATIONAL THERAPY TRAINING: WHAT IS TAUGHT VERSUS WHAT IS NEEDED AFTER QUALIFICATION.**

2.1. The type of activities we're taught and what we need. Although there appears to be an almost general consensus that Occupational therapy training foundations are still the same, OTs are using different activities today. What OTs are taught in training and what is expected from them once they've qualified is not always compatible. Examples were made about being taught activities mostly for treating chronic psychiatric cases but in private sector psychiatry OTs treat mainly acute conditions such as stress and anxiety.

Another example was that while there appears to be a big demand for vocational rehabilitation in the real life situation, OT training still concentrates on "unrealistic" sheltered-employment type of training environments such as Industrial Therapy in

psychiatric institutions, some felt that training to do vocational rehab should involve much more of going out into the work place in the open labour market.

Some felt that "activity" teaching is particularly problematic and that training centers should place more emphasis on activities more realistic and relevant to private sector and community based rehabilitation.. There was also concern that today's OTs were moving away too much from the use of activity and as such their ability to do activity analysis, a skill crucial to OT, was poor.

2.2.Change in the socio-political context:

Post 1994 the dramatic changes in government and consequently also in health care delivery has resulted in a chasmic dichotomy of contrasting extremes to which OTs are currently exposed. Public sector hospitals which are generally understaffed, are poorly resourced, have large loads of patients with often complex and multiple diagnoses (eg.HIV related) referred for OT and very quick turnover of patients resulting in very little time for rehabilitation and the slow implementation of community based rehab services resulting in poor follow up and thus also poor rehabilitation facilities.Students thus mainly exposed to acute remedial treatment rather than rehab.

The public sector community rehabilitation services are even worse off regarding resources and large numbers needing care. These settings often require OTs to be extremely innovative and creative in prioritizing and setting up their treatment programmes. On the other side are the private sector hospitals and practices which are well resourced with modern equipment, single patient or small group treatment at a time and are usually dealing with common types of diagnoses such as stroke, head injury or anxiety disorder. It would appear from what is said that current fieldwork practical training tends to focus considerably more on the public sector scenario rather than the private sector one.This has also brought about major changes in constitution and legislation which OT students need to be acquainted with.

2.3. Shift towards more comprehensive view of human occupation

What appears to be emerging from the comments made by some of the focus group participants is that OT is moving away from the old institutional-therapeutic-rehabilitative mode of using activity into a much more realistic and holistic consultative specialization in Human Occupation. The therapists role has also broadened more to that of consultant and manager and hence skills such as the ability to assess both individual and group deficits in human occupation has increased as has the need to counsel both patient and other stakeholders around issues of human occupation. The implication is that training centers need to carefully re-evaluate their curriculum to ensure that it is providing graduates with the necessary skills to do this.

2.4. Paradigm shift from a medical model to other more appropriate models such as the social model and developmental models. However OTs are still in a quandry as to exactly what particular model to use. Please refer to Point 3 page 3.i.e. Identity Problems, where this is discussed in detail. OTs need new skills and mind-sets in the new health system.The increase in global knowledge makes access to information easier for some.

2.5. Shifts in extremes and emphasis within the various contexts described under 2.2. above

Therapists in public sector hospitals are seeing more acute cases than chronic due to rapid discharge, except for chronic psychiatric institutions. Public sector OTs are also exposed to large numbers of clients at a time with limited resources and more team work, these services are generally overburdened with HIV/AIDS related cases which are often

referred to OT because many of them have neurological problems. The private sector on the other hand sees both acute and chronic cases but on a one to one basis with far more up to date resources for treatment, cases are generally less complicated and there appears to be greater emphasis on assessment and consultation.

3; IDENTITY PROBLEMS: FINDING OUR NICHE.

Within all focus groups there were several comments which indicated the current fluidity of occupational therapy's identity and the need to establish a more permanent one.

3.1. Conflict around models influencing OT: (see point 2.4. page 7 above)

There were repeated references to particularly the medical and social models and Generally there appears to be agreement that OT in South Africa has moved from the medical to a more social model, but although other models are alluded to none of these are mentioned by name. There is also some doubt as to whether we have moved entirely away from the medical model or whether we swing backwards and forwards between models. There is also concern by one that we might adopt models that are not appropriate to the South African context. This lack of clarity over models is seen as having a bad influence on establishing our identity as a profession. But there are others who feel that we're working with a much stronger modelbase, we've become more client-centered with and increasing emphasis on empowerment (*Developmental model?*). The researcher is particularly concerned by the consistent use of Eurocentric models and no attempt to integrate indigenous African models or world views into our unique South African world view such as for example, *Ubuntu*.

3.2. Searching for a NICHE for ourselves:

Some group members feel we are still grappling with our identity as a profession and in flux trying to establish a new NICHE for ourselves having adopted various stances over the years. In the past we were associated more with medical intervention, now we are associated with other non-medical interventions

These views of the profession being in flux around its identity are contradicted by others who feel that OT is much better defined and known today than it was 20 years ago..

3.3. Concern about poaching by other professionals on OT territory.

All Focus groups expressed concern that other professions were "stealing" from OT ideas methods and techniques. This in turn has a negative effect upon the OT identity. This will be discussed in more detail below under Point 4. Blurring of Roles.

3.4. There were also concerns expressed about whether OTs scientific base for practice is adequate or not.

4: BLURRING OF ROLES AND TERRITORIAL DISPUTES:

The introduction of a health care system which is more community based and which is often under resourced has resulted in the need for greater team work and health professionals having to transfer skills across professions, thus for example, the OT would learn some language stimulation from a speech therapist and the OT might pass on some positioning skills to the Speech therapist. In this way roles become blurred but more than that there is also concern that some health professionals have actually taken over roles which really fall within the OT realm and OTs have so much to offer it is easy to poach from them. This is having a detrimental effect upon the OT identity. Another possible cause for this is that there "*aren't enough OTs to make a difference*" and that OTs don't market themselves well enough.

5: CHALLENGES TO OT TODAY.

1. There appears to have been a greater move towards vocational rehabilitation and demands on OTs, particularly in private practice and private enterprise.
2. The enormity of unemployment in South Africa offers a challenge to OT presumably in terms of providing programmes that compensate for work loss and provide meaningful and healthy human occupation.
3. Some OTs in private practices for adults (medico legal) appear to spend more time on assessment than actual treatment. Therefore competency in assessment is crucial
4. With the implementation of more effective disability management by government, there are greater demands for OTs expertise.
5. The increase in HIV/AIDS cases in public sector hospitals has created considerable challenges for OTs and special need for therapists to learn how to deal with terminal conditions.
6. The increase in recognition for the role of OTs in assessment and treatment of medico-legal cases and learning disabilities requires revision of current curriculae.
7. There's been an increase in acute psychiatric cases being referred to OTs in private practice.
8. OTs in SA have to learn to cope under extremes of demands from almost non-existent resources to those with high technical devices and high levels of resources.

6. CHANGING PROFILE OF ROLEPLAYERS/STAKEHOLDERS .

6.1. Clients/patients: The profile has changed within both private and public sectors.

In the past **public sector** hospitals were segregated so that OTs treated clients in racially segregated groups, now all hospitals are integrated and more accessible to previously disadvantaged groups resulting in far greater numbers of ethnic African patients, many of whom do not speak English or Afrikaans. The OT population is still made up of predominantly white females although there are now far more OTs from other race groups with the minority of OTs being ethnic African. This must impact upon both communication as well as sensitivity to cultural nuances. The primary health care ethos influencing public sector health care has resulted in a far greater involvement in District Health Care systems thus OTs in these services are far more exposed to clients and their families and or caregivers as well as other community members such as *inkosis*, teachers, school principals, community health workers etc. than they were in the previously tertiary health care oriented service. Both community and hospital services have far greater intake of clients resulting in OTs having to deal with far larger numbers and groups of clients in order to fit them all in. Thus again the concern for a largely eurocentrically biased training of therapists who are treating a largely afrocentrically biased population.

6.2. Private sector on the other hand has moved from predominantly paediatric physically oriented practices to a combination of both paediatric and adult as well as psychiatry and physical. Many of these adult practices deal with medico-legal cases and insurance agencies dealing with road accident fund victims. As a result OTs have a lot more contact with lawyers, employers and magistrates. They have to be adept at court procedure and dealing with presentation of their findings in a court and under cross questioning from defence lawyers. It is also possible that the paediatric OTs perhaps now have more contact with teachers and parents than in the past.

7. ALTRUISM VERSUS MATERIALISM.

OTs are more money oriented today than they were in the past. There is a general sense from at least two focus groups that OTs are moving from the past altruistically oriented locus to a much more materialistic one.

7.1. OTs appear to be much more concerned today about conditions of service, salaries and chances of promotion. They also appear to be influenced by what medical aids and insurance schemes are prepared to pay for. This could have detrimental influence on retaining the core principles of occupational therapy in use of activity/human occupation as therapy.

7.2. ATTRITION: promotion possibilities and salaries in the public sector are not as good as in the private sector, there is thus a quick turnover of therapists in public sector hospitals. These OTs either leave to go into private practice or to other countries where they can earn two or three times the salaries they would earn here. They also use OT as a stepping stone to more lucrative jobs.

7.2. SOCIO-POLITICAL CONTEXT:

Health care has become more and more controlled by business and income generating principles in both private and public sector. Everything is costed, time costs money, every day longer the client spends in hospital costs more and thus clients are discharged as quickly as possible usually long before they have been properly rehabilitated and the lack of adequate community based rehabilitation has meant many clients are inadequately rehabilitated. Some feel the old "patient care" has disappeared and been replaced by a very merciless system. A beneficial spin off from this "managed health care" is that therapists have to be far more accountable today than in the past because of a greater emphasis on quality assurance.

8. CHANGING MODELS: (See also page 3 point 3.1 OT Identity).

Both in South Africa and globally, OT has been significantly influenced by the dominating models of health care provision of the time. The medical model dominated health care in South Africa in the apartheid days and the current health care system is more influenced by a developmental and social model although there is still an undercurrent of influence from the old medical model. OT appears to be in flux moving between these models. My previous comments about exploration of some African models applies here as well.

9. CHANGING RESPONSIBILITIES.

9.1. OTs are more involved in managerial roles and positions than they were in the past

9.2. they have greater responsibility today than in the past

9.3. in the past they rarely took a lead role in patients treatment programme but this does happen more often today.

9.4. there is much more teamwork and transdisciplinary teamwork which brings with it additional responsibilities and greater accountability'

9.5. In the past the OT was the nurturer and set the pace for treatment and the patient was more a passive recipient nowadays, partly because of rapid discharge, the emphasis is on empowering the patient and making him/her take responsibility for his/her rehabilitation after discharge and mobilizing resources to assist with ensuring this occurs.

9.6. In the past treating the patient kept the OT "happy" and "fulfilled" the OTs needs in terms of feeling "good" about helping an individual with a disability to improve (smugness) but we weren't necessarily fulfilling their (the patient's and specifically the ethnic African patient) needs because we didn't have the language ability (or adequate insight into their cultures) to adequately fulfill these needs.

9.7. The lack of transparency regarding the HIV/AIDS epidemic and the “playing cagey” around openness in the approach to holistic treatment of the disease makes it very difficult for OTs to deal with these problems. (Surprisingly this was the only direct reference to HIV/AIDS in the entire four focus groups.)

ANALYSIS OF FOCUS GROUP'S RESPONSES TO QUESTION 2:

“ Do you believe the demands in clinical reasoning and clinical competence has changed over the past 20 Years?

1. As this question was fairly similar to question 1 many of the responses are already included in Q1 however a few relevant points arose as follows:

- 1.1. Clinical reasoning evolves with experience it is a dynamic process.
- 1.2. Today's approach to treatment is much more focused and scientifically based thus making it necessary for OTs to work in a much more clinically reasoned manner.
- 1.3. OTs today have to be much more aware of their clinical reasoning skills than in the past
- 1.4. Today's OTs much less likely to follow treatment recipes than in the past because of complex cases and often multiple diagnostic nature of their cases cannot resort to a recipe, have to clinically reason much more.

2. What did clearly arise out of responses to this question was that today there is **a much greater need for accountability, quality assurance and professionalism** which appears to have arisen as a result of the following:

2.1. The ongoing process of **Transformation** taking place in South Africa as a result of the change to a democratic Government in 1994. This has resulted in major changes in policy, legislation and provision of services within Health, Education, Welfare, Labour and particularly Human Rights all of which have relevance for Occupational Therapy. This also means that South Africa is moving from a developing to a developed country resulting in OTs having to accommodate and be accommodated in multiple transformatory processes.

2.2. As a result of 2.1. above **greater conscientising of all South Africans to their right to quality and efficient services** and their subsequent demand for this is putting pressure on health care workers/professionals to provide such services.

2.3. Greater numbers of occupational therapists going into **private practice and private enterprise** combined with a much greater global emphasis on consumerism.

As a result of the concomitant effect of all three of these factors the following is of relevance to occupational therapy in South Africa:

- New discoveries and developments within the profession has resulted in a shift from the prescriptive, reductionistic medical model to greater emphasis upon more empowering developmental and social models of intervention
- In the past there was little emphasis upon accountability today there is considerable emphasis upon it in all sectors i.e. public and private
- Consumers today are much more aware of their rights and thus much more demanding of good service
- OTs much more client centered today than in past where they tended to be more therapist centered

Maintenance of quality is an ethos which is ongoing and enforced in the form of Continuing Professional Development requirements stipulated by the Health Professions Council of SA.

- OTs much more involved in formulating and implementing policy and thus also a need for awareness of relevant legislation

- Greater need for OTs to assess accurately and to work with greater efficiency and at greater speed than in the past.
- Greater need to be focused and make use of proper scientific methods of assessment and treatment
- Greater need for and implementation of measures to determine levels of efficiency of OTs
- Much greater emphasis on professionalism in every sphere, appearance, reporting, interaction with all stakeholders etc.
- Private sector demands for quality assurance are extremely high as people are now paying high prices for such services and expect the best. Although this is similar for public sector, the emphasis is not as great implying that public sector service is inferior to private.

3. Skills and Competencies that need to be added to the curriculum or reviewed in existing curriculae and therefore also need to be assessed in final year OTs are:

- Prevocational and vocational assessment and training
- Greater need for medico-legal skills and knowledge of court/legal procedure
- Greater demands for managerial and administrative skills, especially related to Community Based Rehabilitation.
- Greater demands for Disability Grant assessments
- More senior OTs now in higher positions thus need for assertiveness and decision making skills as well as knowledge of relevant legislation and policy.
- Greater need to be able to market our profession better and create a better identity
- More need for transdisciplinary, multidisciplinary skills
- Greater need to deal with terminal diseases such as HIV/AIDS and other emergent conditions.

4. Other points of relevance:

- OT is more recognized today than in past because of our widening role and thus contact with more roleplayers e.g. community and legal areas but we are still having problems with getting adequate recognition for our role
- Today's students much more assertive in terms of their rights etc.

ANALYSIS OF FOCUS GROUP'S RESPONSES TO QUESTION 3:

"Do you believe that as OTs in Africa we have something unique to offer the rest of the world?"

Four issues arose out of the responses to this question viz:

- 1) The **unique South African situation** which, because of a combination of dynamics has spawned occupational therapists which have unique and special skills making them competent to work anywhere in the world.
- 2) The **unique characteristics, skills and abilities** that South African OTs have acquired because of factors arising in (1) above.
- 3) The way **occupational therapy training** in South Africa has adapted to accommodate the unique African context.
- 4) **Deficits, i.e. things South African OTs are not good at.**

1) The **unique South African situation**: South Africa has developed into what it is today through a combination of complex and dynamic, negative and positive, historical and extant forces. These are alluded to in the Focus groups and they include colonisation with its strong

Eurocentric influences, the many years of apartheid and the effects of this regime, the diversity of indigenous and other cultures that currently make up the South African population, the mixture of language systems, indigenous African influences e.g. traditional medicine and specific occupations of African peoples. This scenario is further challenged by the mix of first and third world that still exists in South Africa today.

There are currently high levels of poverty, crime and violence in this country which together with the very large numbers of persons with HIV/AIDS has created a patient population that more often than not presents with not only multiple and complex diagnoses but a whole array of additional biopsychosocial complications and sequelae.

The constant transformation that has been taking place and continues to occur in an attempt to reverse the inequities of apartheid and keep up with the demands of globalization has resulted in dramatic changes in focus and ethos of health care delivery, shifting from a curative, tertiary based ethos and setting to a preventive, promotive and community based setting (District Health System) with a Primary Health Care ethos. Delays in implementing these changes have resulted in the District Health Systems having been largely under-resourced particularly with regard to rehabilitation.

This complex set of dynamics has impacted more positively than negatively on the type of occupational therapist South Africa is currently producing. These positive and negative influences will be discussed hereafter.

2) Unique characteristics, abilities and skills nurtured by (1) above:

- Creative, innovative and lateral thinkers
- Good at problem solving and clinical reasoning because of constant exposure to complex cases and minimal resources
- Flexibility and the ability to compromise and function adequately in situations with minimal resources as well as work in well resourced and high technology situations.
- Bored by too much routine and prescriptive/menu treatment protocols as set out in e.g. managed care systems
- Hard workers
- Independent workers
- Are not as Model-bound as their Western colleagues
- More "hands on" and multi-skilled e.g. because of need to have to make splints and assistive devices rather than order them, as well as following patients progress from admission to reintegration into community which is unlike Western countries where diversification of roles and variety of health care professionals/workers results in some of these activities being taken over by others.
- Able to adapt techniques and tests from other countries to meet needs of South Africa
- Able to work with large numbers of patients at one time and over prolonged periods of time
- Probably more able than elsewhere in the world to deal with relevant issues related to persons with HIV/AIDS due to increasing exposure to very large numbers of individuals with HIV/AIDS related complications affecting function.

3) The manner in which occupational therapy training has adapted to accommodate the unique South African context.

- The quality of undergraduate training is good as students are generally exposed to patients, situations and scenarios consistent with those arising out of the context

described in (1) above. This exposure helps build the characteristics, skills and abilities described in (2) above.

- The training is tough and because students frequently have to deal with difficult and complex situations and patients it results in more rapid maturation
- The exposure to first and third world situations and technologies equips them to work in any setting in the world

4) Deficits: problem areas.

South African OTs:

- don't market themselves adequately and don't "brag" or try and sell their successes, they lack the confidence that their Western colleagues possess.
- to market themselves are not assertive enough in challenging others about issues they oppose or don't agree with
- are not producing enough research or publications which could partly be as a result of heavy work loads and large numbers of patients but also other reasons such as lack of confidence in doing research
- Have developed some good ideas and theories e.g. Creative Participation, but don't make enough effort to share these with rest of world
- Are still too bound by Eurocentric origins and influences and have not considered the importance of inclusion of Afrocentric origins so essential for our survival as a profession in this continent.

ANALYSIS OF FOCUS GROUP'S RESPONSES TO QUESTION 4:

" Do you think that the current methods used in the training centers you are involved in, adequately assess the final competencies required of the student graduating as an OT?"

Introduction: Most groups were generally of the opinion that OT training and assessment of final competencies was adequate in South Africa. They qualified this by the fact that our graduates are so willingly recruited by Western countries such as USA, UK, New Zealand and Australia. However there were also many comments which indicated that all is not so well as far as the curriculum and assessment of final competencies was concerned. The researchers particular concern is that we are primarily training OTs for SA and that is where the focus of our attention should be, it may be flattering that they can work well in other countries but how well are they really meeting the relevant health needs of our country?

The following broad themes emerged:

1. Existing methods of assessment commonly used in OT training centers in SA
2. The changing nature of the assessment process as a result of ongoing transformation in SA and the constantly changing face of health delivery locally and globally.
3. New and developing aspects of assessment that need review and/or revision.
4. Desirable characteristics of a graduating OT
5. Problem areas and gaps in the current assessment process
6. General principles of importance in the assessment process
7. Considerations for determining criteria for what constitutes a "fail".
8. Some possible methods for overcoming problem areas and gaps.
9. Miscellaneously related issues.

1. Existing methods of assessment commonly used in SA training centers.

Some group participants feel that OT training in SA has generally been using certain assessment methods for 30 odd years without really evaluating their efficiency and suitability for assessing the competencies required of OTs in South Africa today.

It appears that although some more innovative methods of using some of the old methods have been introduced, for example videotaping patients for case studies and providing "paper" patients, they are all variations of the old theme of case study coupled with written tests and examinations and some practical skills assessment included in OSPE/OSCE type tests and examinations.

It was also felt by some that the current training and assessment of competencies to work in the community at some universities was adequate.

2..The changing nature of the assessment process as a result of ongoing transformation in SA and the constantly changing face of health delivery locally and globally.

Currently the constancy of change in South Africa is an ever present phenomenon as a result of several factors i.e. the inherently evolving and developing nature of health care delivery, the ongoing process of transformation still underway in South Africa and access to the rapid generation of new knowledge in the currently sophisticated global technological arena. Consequently it is essential that, as with the curriculum, the process and procedures used in the assessment of final competencies in graduating OTs must keep abreast with this dynamic process. This indicates the need for a consistent process of symbiosis between the OT training centers and the providers of OT services as well as a constant scanning of the various environments, components and aspects which are of relevance to OT training e.g. Legislation and Policy, local and global trends in health and disease, needs related to the broader/healthy/rehabilitated population regarding human occupation and our role in promotion of healthy living and prevention of disability in those at risk.

This might necessitate inclusion of new and important aspects as well as exclusion or revision of old and redundant aspects. For example, with the current legislation for compulsory community service of newly qualified OTs it has emerged that they require more and better skills in the field of management and administration especially regarding those required to start a new occupational therapy service. However within the next 5 or 10 years those services now newly started will be up and running and the need for such skills and knowledge will have diminished.

3.New and developing aspects of assessment that need review and/or revision.

3.1. The emphasis on community service has resulted in the need for inclusion of a whole new set of knowledge, ethos, skills and attitudes with their concomitant assessment requirements. These include among many others the following:

- The ability to be able to rapidly assess ("on the spot") and make immediate decisions about the treatment interventions and referrals necessary for the client
- A lot of additional management and administrative skills such as proposal writing, setting up new services, fund raising etc.
- Transdisciplinary teamwork

3.2. the need for more management and administrative skills has broadened all round, not just because of more community service, but also because senior OTs are being promoted to higher ranks and incorporated into decision making and management at much higher levels than in the past.

3.3. The transformatory process with its generalized dramatic changes in legislation and implementation of services has resulted in major legislative and policy changes which it is

essential for current-day therapists to be aware of and to have a working knowledge of the relevant legislation and policies and strategies for their implementation.

3.4. There is greater need for knowledge at an undergraduate level on medico legal work and knowledge of court and legal processes related to third party claims, etc.

4. Desirable characteristics of an OT graduating today :

4.1. The ability to "think on their feet", this is particularly related to point 3.1 above but is a generally desirable trait for all forms of practice. This phrase "think on their feet" is one constantly used to define OTs and needs to be fleshed out and more clearly defined.

4.2. Flexibility and ability to adapt to any environmental, cultural or other related contexts be they ones where poverty or affluence abound.

4.3. They need to have *critical* clinical reasoning ability.

4.4. Must demonstrate certain essential professional behaviours which need to be clearly defined by the occupational therapy profession.

4.5. They need broad-based rather than specialised skills.

4.6. They should demonstrate a propensity for life-long learning

5. Problem areas and gaps in the current assessment process

5.1. Although there are generally efficient assessment methods in place in training centers to assess competencies such as knowledge and skills it is in the area of assessment of the more difficult "qualities" (rather than competencies) such as desirable attitudes, values and professionalism that there are inadequacies and gaps.

5.2. there is still not absolute agreement as to what particular competencies should be considered the final ones and how these should be integrated into the training process, this creates a sense of vagueness about exactly what it is we should be assessing.

5.3. We haven't yet established the appropriate balance or weighting between knowledge, skills and attitudes.

5.4. Some feel that we "over-examine" whereby the student is constantly assessed with written and practical assessments throughout the year and then still subject to a final grueling written and practical examination process at the end of it.

5.5. The weighting of the year mark (CAM) to the exam mark is generally skewed too far in favour of the examination mark i.e. 50:50 when the year mark represents far more input.

5.6. There are problems with the process of quantifying and qualifying what constitutes a pass and fail and this is made worse by blatant areas of unfairness inherent in our assessment processes. These will be discussed under point 6 below.

5.7. The examination process does not provide a true reflection of the students ability because:

- it is extremely stressful and we are not trying to examine the students ability to cope with stress but their knowledge, clinical skills and attitudes and values.
- In case studies the fairness is questioned because of the often extreme differences in complexity of cases presented, some may be fairly straight forward while others may be extremely complex.
- Unfairness also occurs because of the subjectivity of the examiners.

5.8. Clinical supervisors are often inadequately prepared to assess day to day competencies of the students under their supervision. This results in some students with problems being identified too late or slipping through on their clinical performance mark because supervisors may find it difficult to fail them.

5.9. It is necessary to look at the weighting of summative versus formative and generic versus clinical competencies within the assessment process.

5.10. Training centers appear to be placing too much emphasis on training students to work in public sector and very little on working within private sector when in reality many graduates go into private sector a few years after qualifying.

6. Considerations for determining criteria for what constitutes a "fail".

6.1. There are some very specific (intangible/abstract) qualities related to professionalism, attitude and values which essentially should be demonstrated before the student is in a position to graduate and be let loose on the public. Some of the group participants felt that however competent the student may be in theoretical knowledge and clinical skills, if they lacked essentials for professionalism they should fail.

6.2. We thus need to identify criteria for failure related to these qualities.

6.3. We need to qualify and/or quantify what gives us "gut feelings" about the readiness or not of the student to pass or fail.

6.4. Concern was expressed about those students who may present seriously unprofessional behaviour on practicals but who still slip through on their clinical mark.

6.5. What is considered extreme before we fail a student? The issue of putting a patient at risk or in danger was considered a definite fail factor but there must be others which we should consider.

7. Some possible methods for overcoming problem areas and gaps.

- 7.1. We need to implement a system of checks and balances to ensure thoroughness but also to prevent over-assessment
- 7.2. the focus of the assessment process should be to evaluate knowledge, clinical competence and correct attitudes, values and professional behaviour not to evaluate the ability to cope with stress.
- 7.3. Establish criteria for exactly what constitutes a pass and a fail.
- 7.4. If a student does really well on his/her year mark (CAM) they should be considered for exemption from the final examination
- 7.5. We thus need to look at using the CAM mark more creatively. Currently too much hangs on the final examination mark i.e. generally appears to constitute 50% for most training centers and this is based on assessment of about a week or two of work as opposed to the many weeks dedicated throughout the rest of the year.
- 7.6. Allowing students to select their own patients for the examination and
Having more control over what they wish to present could allow for more objectivity and less stress
- 7.7. Continuous on site assessment of students while they are on practical blocks would probably provide a more fair and realistic form of assessment on overall competency than the examination does.
- 7.8. More consideration should be given to a National examination which would mean standardization across all training centers.
- 7.9. Peer evaluation together with clinical therapists and lecturers may increase fairness and objectivity.

8. Miscellaneous: related issues.

- a. Not enough time given to training students and assessing their ability to supervise OTAs/support staff and this is becoming more and more of an issue.
- b. There is not enough time to train all we need to know should consider an additional 6 months to a year which would allow for development of specialization at this level.
- c. selection of students is an important issue, it is not the type of degree that makes the student but the type of student that takes the degree and these need not necessarily be academic "whiz kids." Some of the strugglers often make the best OTs
- d. Students from disadvantaged educational backgrounds do not always have their problems identified early enough.
- e. Governing bodies e.g. HPCSA can interfere with how training centers assess competencies.