S., Coleman, G., & Lane, C. Verification and clarification of patterns of sensory integrative dysfunction. American Journal of Occupational Therapy, 2011 ;65 (2): 143-151.
5. Smith Roley, S., Mailloux, Z. Miller-Kuhanek, H. & Glennon, T. Understanding Ayres Sensory Integration®. OT Practice, 2007; 12(17): CE1-CE-8.
6. Smith Roley, S. Evaluating sensory integration function and dysfunction. In R.C. Schaaf. & S. Smith Roley (Eds.). Sensory Integration: Applying Clinical Reasoning to Practise with Diverse Populations, 2006; (15 – 36). Austin, TX: Pro-Ed.
7. Ayres, A. J. Southern California Sensory Integration Tests. Los Angeles, CA: Western Psychological Services, 1972a.
8. Van Jaarsveld, A., Mailloux, Z. & Herzberg, D. S. The use of the Sensory Integration and Praxis tests with South African children. The South African Journal of Occupational Therapy, 2012; 42(3): 13-18.
9. Ayres, A. J. Patterns of perceptual-motor dysfunction in children: A factor analytic study. Perceptual and Motor Skills, 1965; 20: 335-368.
10. Ayres, A. J. Interrelations among perceptual-motor abilities in a group of normal children. American Journal of Occupational Therapy, 1966a; 20(6): 288-292.
11. Ayres, A. J. Interrelationships among perceptual-motor functions in children. American Journal of Occupational Therapy, 1966b; 20(2): 68-71.
12. Ayres, A. J. Deficits in sensory integration in educationally handicapped children. Journal of Learning Disabilities, 1969; 2(3): 44-52.
13. Ayres, A. J. Types of sensory integrative dysfunction among disabled learners. American Journal of Occupational Therapy, 1972b; 26(1): 13-18.
14. Ayres, A. J. Cluster analyses of measures of sensory integration. American Journal of Occupational Therapy, 1977; 31(6): 362-366.

❑

Corresponding Author
Anne-Marie van Jaarsveld
Gnatavj.md@ufos.ac.za

Experiences of mothering drug-dependent youth: influences on occupational performance patterns

Lisa Wegner, BSc OT (Wits), MSc OT (UCT), PhD (UCT)
Associate Professor and Chairperson, Department of Occupational Therapy, University of the Western Cape

TeriLee Arend, BSc OT (UWC)**
Raagiema Bassadien, BSc OT (UWC)**
Zulfa Bismath, BSc OT (UWC)**
Lauren Cros, BSc OT (UWC)**
**Students in the Department of Occupational Therapy, University of the Western Cape at the time the study was carried out

ABSTRACT

Substance use by youth in South Africa is a serious problem. The prevalence of substance use and the influence on individuals has been well researched; however, little is known about the experiences of mothers of drug-dependent youth. In this study, a qualitative approach was used to explore how the occupational performance patterns (roles, rituals, routines and habits) of mothers were influenced by the addictive behaviours of their drug-dependent, young adult children. The participants comprised six mothers of youth who were in-patients at a drug rehabilitation centre in Cape Town. The social worker and the occupational therapist at the centre were key informants. Data were gathered through individual interviews with the key informants and two focus groups with the mothers. Five themes emerged from the thematic analysis of the data: (1) "They take everything" (2) "The peace keeper" (3) "I can't take it anymore" (4) Role plays of mothers (5) "We also still need a life". The study contributes to the knowledge base of occupational science by providing insight into the occupational challenges experienced by mothers of drug-dependent youth. There is a need for interventions that support and promote the wellbeing of mothers such as these.

Key words: Addictive behaviours, mothering, occupational performance patterns, substance use

INTRODUCTION

Substance use by youth in South Africa is a serious problem. Specifically, the Western Cape Province has become one of the regions in the world with the highest prevalence of methamphetamine use[1]. Methamphetamine, known locally as "tik" for the popping sound it makes when heated, has severe side effects including psychosis, aggression, depression, weight loss, and is associated with sexual risk behaviour[1]. Currently, methamphetamine is the primary drug of abuse for 39% of patients admitted to a substance abuse treatment center in Cape Town[2]. In South Africa, research related to substance use has focused on the nature and extent of abuse and the associated risk factors for individuals who are addicted to substances. Less is known about the social and health consequences for families of addicted individuals.

The media has focused attention on the effect of drug use on families, and mothers in particular. Probably the most well-known story is that of Ellen Pakkies, a mother from Cape Town, South Africa, who murdered her methamphetamine-addicted son. An article that appeared in a Cape Town newspaper[3] explained why Ellen Pakkies murdered her son, placing emphasis on her physical and social context and describing the difficulties that she endured due to her son's addictive behaviour. Sadly, this story is not unique, and is commonplace in many homes in Cape Town[4]. Another example is Portia Bam, mother of a drug-dependent teenage daughter, whom she said would either kill her, or be killed, as the only means of escape from their misery[5]. These media articles portray the struggles that mothers endure in caring for their drug-dependent children, and the lengths to which they can be driven. Helen Zille[6], former

Mayor of Cape Town from 2006 until 2009, argued that substance abuse and addiction are in many cases linked to theft, violence, crime and gangsterism, and are factors which tear families apart and ruin the lives of youth in particular.

The effect of drug use on families was highlighted in a qualitative study conducted in Brazil that investigated the effects of children's cocaine-dependence on the nuclear family[7]. The authors compared 67 case triads (including mother, father and son) selected from two mental health facilities with 67 control triads, and found signs of nuclear family triangulation (which can create tension and anxiety as one part of the triad may feel left out and compete for attention) within families where there was drug dependence. In addition, case triads were significantly more likely to experience family functioning as enmeshment[7] which can be dysfunctional due to an over-involvement in one another's emotions and a lack of boundaries, leading to loss of emotional identity. In other words, having a drug-dependent child may place a relatively greater strain on the relationship between parents and create power struggles as well as stifle autonomy, further feeding into a child's drug-dependence.

The transition from late adolescence to early adulthood can be difficult for both the youth and their mothers, as young adults establish their identities, define their values, become independent, assume adult responsibilities, and develop intimacy with, and commitment to, others[8]. Mothers generally anticipate that their young adult children will obtain increased independence after they complete high school[9]. Coping with the transition can be more than ordinarily challenging for all concerned when young adults are also drug dependent.

Understanding addiction from an occupational perspective contributes to the knowledge base relating to substance use. Helbig and McKay[10] provide a theoretical account of addiction as a meaningful life role, albeit one that is associated with dysfunctional occupational performance. Long-term drug addiction results in a reduction in occupational choices and opportunities and is associated with occupational risk factors[11] as the addict strives to maintain the addictive behaviour. Occupational imbalance[11] occurs as the addict devotes more time to accessing and using the substance, leaving less time for other occupations. Occupational deprivation[11] is both a cause and a consequence of addiction; for example, an individual may use substances to deal with boredom in free time as there is a lack of leisure resources in the community[12]. The addict may face unemployment and poverty because of substance abuse[10]. Occupational alienation[11] may occur as the addict withdraws from everyday life into his/her own world of addiction. It is clear that addicts experience dysfunction, but the question arises: what is the influence of addictive behaviour on the occupational performance of families, specifically mothers?

With a view to understanding the occupation of mothering, an examination of the literature regarding parenting showed that traditional divisions of household work with separate routines resulted in a "parenting style of maternal responsibility and paternal assistance", where mothers carry primary responsibility for child care[13:25]. Alternatively, parents who adopted a non-traditional division of household work by sharing routines displayed seamless and uninterrupted child care by either the mother or the father. However, despite recent moves to redefine fatherhood, there is strong evidence across the world that the majority of household work including child care, still falls on mothers regardless of whether they work or not[14]. Thus, it is mostly mothers who assume the role of primary caregiver[13].

Considering the extent of drug use, the occupational dysfunction resulting from drug use, and the primary caregiver role of mothers, it is surprising that no previous studies have sought to understand how the addictive behaviours of drug-dependent, young adults influence their mothers. Therefore, the question addressed by this study is: how are the occupations of mothers influenced by having to care for, and support, a drug-dependent child? Specifically, we were interested in how mothers' occupational performance patterns – or in other words their roles, habits, routines, and rituals that enable participation in occupations – were affected by their young adult children's substance use and addictive behaviour.

According to the Occupational Therapy Practice Framework[15:643], occupational performance patterns are defined as "the patterns and behaviour related to an individual's daily life activities that are habitual or routine"; roles as "a set of behaviours expected by society, shaped by culture, and may be defined by the person"; habits as "automatic behaviours that can be useful, dominating or impoverished, or these could either support or interfere with performance in areas of occupation"; routines as "patterns of behaviour that are observable and frequent that provide structure for daily life"; and rituals as "engagement in symbolic actions with spiritual, cultural or social meaning which contribute to the person's identity".

METHODS

A qualitative approach was used to explore the influence of young adults' addictive behaviour on their mothers' occupational performance patterns (roles, rituals, routines and habits). The study was conducted at a drug rehabilitation center in Cape Town that admits adults aged 18 to 60 years who are diagnosed with alcohol and/or drug-dependence for a seven week treatment period.

Participants

The occupational therapist and social worker at the center were identified as key informants because of their direct experience in working with in-patients and their families. Convenience sampling was used to recruit mothers who visited the center on two consecutive Sunday afternoons in August 2011. Mothers of young adult in-patients aged from 18 to 24 years, were invited to participate in the study. This resulted in a sample of six participants whose ages ranged from 45 to 56 years. Four of the mothers were employed (call center consultant, housekeeper, human resource worker, self-employed), one was a housewife and one was a pensioner. They had between three and six children, with, on average four children each. Four of the mothers also had grandchildren. All of the mothers were living in lower socio-economic communities in Cape Town.

Data collection

In preparation for data collection, media clippings in the form of television stories and newspaper articles of Ellen Pakkies and other similar stories were perused to provide insight into mothers' experiences of the addictive behaviour of their young adult children. Two methods of data collection were used: firstly, a semi-structured interview was conducted with each key informant to obtain their perceptions of the influence of addictive behaviour on the occupational performance patterns of mothers. This process informed the development of interview questions for the focus groups with mothers. Secondly, two focus groups were held with the participating mothers. A semi-structured question guide was used to elicit the mothers' experiences of caring for drug-dependent young adult children, and explore their perceptions of how the addictive behaviours of their children influenced their daily lives, relationships, roles and activities. Examples of questions were "What does it mean for you to live with a child who is a drug addict?", "How are your other relationships affected?" and "What are the difficulties you experience?" The focus groups established universality among the participants, which promoted interaction and detailed discussions. The focus groups were conducted at the drug rehabilitation center on two consecutive Sundays during visiting hours. The same researcher facilitated both focus groups, while the other researchers made observations and took notes. Each group lasted one hour and was audio taped to record the responses of the participants.

Trustworthiness

Trustworthiness was ensured through triangulation of multiple data sources (media clippings, key informants, participants); data-gathering methods (semi-structured interviews and focus groups); and the use of a team of researchers. Reflexivity[16] is another means of ensuring trustworthiness and occurred as each of the researchers interrogated their personal experiences with substance use and reflected on their unique perspective on the subject.

Data analysis

The audio-tapes of the focus groups were transcribed verbatim. The data was analysed thematically whereby the researchers identified codes, grouped similar codes into categories and finally into themes by searching for patterns[17]. The process of identifying codes and categories was conducted by each researcher independently. Thereafter, the researchers discussed their preliminary analyses, further developed categories and then finally themes. Participants' quotes were used to support and highlight the findings.

Ethics procedure

After ethical approval was granted by the University of the Western Cape, the Director of the drug rehabilitation center gave permission to conduct the study. The key informants and participants gave their informed consent in writing. All participants understood that identities and information would remain confidential, that opinions would be respected and no judgment would be made on participants within the focus groups. Participation was voluntary and participants were able to withdraw at any point in time without consequences. Provision was made for the participants to discuss any issues or topics that arose from the focus groups with a counselor at the center. It was anticipated that the participants would benefit by sharing their stories, thus obtaining a sense of universality from their similar experiences.

FINDINGS

Five themes emerged from the analysis of the focus groups.

Theme 1: "They take everything"

Mothers perceived their drug-dependent children as taking everything from them as the drug user's priorities are pitted against those of the mother. Mothers recounted how the drug-dependent, young adults demanded their undivided attention, stripped them of their health and belongings, negatively influenced their relationships with husbands and destroyed the trust they once had in their children. Mothers described how their children would go to any lengths to obtain the drugs they need in order to satiate their cravings, regardless of the consequences and pain it caused their loved ones. Often the young adults resorted to theft, and the vanishing of assets was a major concern in the homes of the mothers. One mother explained:

"All your - most of your furniture they take out they sell it. …sometimes I put things in the cupboard or they sell um, glasses that is repacked glasses that's new that they can sell so that they can just get money, for a R10! For a R5!" (participant 4).

Mothers were willing to use all available finances and drain all accounts in order to cover the costs of rehabilitation, as indicated by a key informant:

"We just had a client now the other day where the Mom actually made a loan against her pension of R50 000 to get the child into a rehab center." (key informant 1).

The mothers emphasised that feeding the habit of their children was a huge financial burden. For example, one participant said:

"And I have had to run to court to bail him out too many times and I'm really sick of it." (participant 1).

Caring for a drug-dependent, young adult was time-consuming and demanding for mothers as they adapted their routines and habits to accommodate their children's lifestyles. The mother's priority becomes caring for the drug-dependent young adult and in doing so she is forced to neglect other roles such as being a mother to her other children, a wife and a worker. Many of the mothers had certain routines they carried out at specific times, such as going to bed at a regular time each night. However, now that they were faced with the challenge of having to care for their drug-dependent children, carrying out these routines became impossible. This had a major impact on the mothers' health and wellbeing. Mothers repeatedly pointed out that they were unable to sleep if their children were not at home. Instead, their routine became one of sleepless nights so that they could monitor the behaviour of their children as this mother said:

"…now I can't sleep if my child's not in the house and my sleep time is 10 o' clock." (participant 4).

One mother expressed her frustration when her routine of meal preparation was altered describing one particular evening when her child had stolen the food:

"…especially when the things are on special and now you buy a lot of chicken…and then you come to the fridge, want to cook…where's the food?" (participant 3).

After all the theft and lies that the mothers were told, the trust that they once had in their children was lost. Little things like allowing one's child to stay at home while the mother was away were no longer seen as insignificant, as the mothers were afraid that their belongings would be stolen by their children or that they were using drugs in the house. Many of the mothers adapted by adopting new habits such as locking up groceries and locking their bedroom doors in order to prevent theft in their homes as highlighted below:

"Usually I could have gone out and left him. He was a very responsible child. He was a trustworthy child…but later you couldn't trust him. I had to lock my bedroom door, I had to put my groceries in there. I had to lock it up in there." (participant 3).

As theft became a significant aspect in the families' homes, the mothers found alternative ways of keeping their money safe. Some resorted to keeping their money hidden on their bodies, even at night as one mother expressed:

"I take my money out. I put it in my breasts or my panties when I go and sleep! What must I do? It's my money." (participant 4).

Some mothers felt that their relationships with their other children were negatively affected as they focused more attention on the drug-dependent child. In some cases, siblings who felt neglected by their mothers and threatened by the drug-dependent sibling moved out of the house, thus further distorting the mother's relationship with her other children as illustrated below:

"...so his behaviour has affected me in a very bad way...because my eldest son actually moved out of the house because of him. He's never coming back. He's staying with his gran at the moment and he doesn't want to speak to him." (participant 3).

Theme 2: "The peace-keeper"

Being "the peace-keeper" describes the mothers' role as enablers of their children's addiction. It encapsulates the ambivalence that mothers experienced especially during the initial stages of realising that their children were drug-dependent. Every mother talked of her devotion to her child, combined with a sense of disbelief and denial that her child was using drugs:

"I also love him a lot, so I will always tell him that I love him you know. 'I love you so much! Why do you do this to me? Why do you have to break my heart?' " (participant 5).

The mothers expressed their fears about their children being involved in risky behaviour that would have serious consequences such as ending up in prison, contracting HIV, and even death. One mother feared that her daughter was selling her body in order to satisfy her drug habit. Fears such as this drove the mothers to keep the peace by supporting their children's drug habits, as they would rather have them make their money in 'safer' ways than resort to acts that could ultimately have negative consequences. As a result, the mothers became the enablers as they attempted to protect their children from danger. Drug-addicted youth are aware of this and depend on their mothers being enablers by protecting them, as this key informant said:

"… the clients also say 'My mom will never put me out' " (key informant 2).

Often, the mothers (as wives) kept certain things about their children away from their husbands. Some mothers regarded this as detrimental to the dynamics with their spouses, yet many chose to do this in order to keep the peace for the sake of their children, as this participant said:

"I'm hiding the really, really, difficult things from my husband. If he must know what I'm going through, then he will tell me immediately, 'Go put him out!' " (participant 5).

Theme 3: "I can't take it anymore"

The quote "I can't take it anymore" epitomises the desperation and powerlessness experienced by the mothers. The mothers' hopes in their children eroded over time due to the continuous broken promises. Mothers spoke of their children telling them time and time again that they were finished with drugging but then relapsing, as this mother said:

"I can't take it anymore! He cries, he apologises, he cries, he cries on my shoulder, thought it would help …he goes back next week again. No, doesn't help. Comes back into the same things." (participant 4).

False hope and broken promises led to mental anguish; as a result, mothers ended up doubting themselves, seeking professional help, or in one case, being institutionalised for a psychiatric problem. This caused mothers to become angry with their children, forcing them to say and do things completely out of character. The frustration experienced by the mothers often led to physical aggression as one mother said:

"I was so angry with him that one day I just snapped and I took the spade and I stood in front of him … and I told him 'I will kill you with this spade!' " (participant 3).

Once the mother reaches the point of desperation she ultimately becomes powerless as a result, with limited, or no, options to help her child. The quote below captures the concerns of the mothers about how helpless they were in bringing about changes in their children's lives:

"*You don't know what else to do man!" (participant 2).*

Theme 4: Roles played by mothers

The mothers described the different roles which they played and explained how these were affected by the addictive behaviour of their children. For example, some mothers' indicated how their ability to perform at work was affected. The following quote recognises one mother's difficulty attending work regularly, and her inability to concentrate and be positive:

"I had to stay out of work many times to go and attend court and to bail him out. And also in my line of duty, the work I do, call center, you have to have a positive mind. So when I get calls that he's in there (prison) then it affects my work." (participant 1).

Some mothers felt unable to fulfill their roles as grandmothers as they were forced to adopt a parent role with their grandchildren due to their children's inability to care for their own children. The mothers spoke about how their children were incapable of caring for themselves let alone their children. This resulted in an added financial burden for the mothers as they received no financial support from their children as this quote shows:

"I think also with regards to finances, a lot of our clients are parents themselves, but they don't look after their kids. So their mothers are looking after their kids." (Key informant 2).

Despite having endless worries and burdens, mothers still extended their motherly love to the friends of their drug-dependent, young adult children and in one case, to street children. These mothers felt that by trying to help children in their community with a drug-related problem, their children would have a better chance of staying away from drugs and changing their lives in a positive way.

Theme 5: "We also still need a life"

The mothers expressed the desire, and need, to still have a life as indicated by the quote in the title of this theme. They described many aspects of performing the mothering role with regard to their other children, their husbands, their extended family and their communities. It was evident that the mothers, despite experiencing various challenges within their lives, found various ways in which to cope with the behaviour of their drug-dependent children. In speaking about their need for a life, the mothers shared various ways in which they learned to cope. Examples included attending church, threatening their children with the reality of the risks associated with their drug-dependence, and returning money which their children stole from people to avoid more trouble. One mother expressed how she tried to make her son realise that he had a drug problem:

"You [are] a tik addict! That's what I said to him. Admit that you a tik addict! Say to yourself, 'I am a tik addict! I am a tik addict!" (participant 4).

Another mother explained that once she had accepted her child's drug addiction she was able to stop defending his problematic behaviour. Although these mothers struggled to overcome the anguish of having a drug-dependent child, they were still hopeful that their children would recover and rid themselves of their addiction. It was clear however, that many of the mothers' hopeful feelings were not merely restricted to their own children, but were extended to the community as well. The mothers understood that the community played a major role in influencing the younger generation either negatively or positively, and believed that a change in the attitudes and mindsets of the community would assist in positive changes in their children as this quote indicates:

"If all the parents can stand together then we can get a better community." (participant 5)

However, despite having their coping mechanisms, the mothers voiced their concerns about coping with the challenges of mothering a drug-dependent child, and identified their need for support, and opportunities to care for their own health and wellbeing:

"They must help us. We can't do it on our own. We [are] only tiny. They [are] the big guys. We [are] only the small ones." (participant 4).

The need for support for mothers of drug-addicted children was supported by both key informants:

"Definitely yes. There's no doubt that they [mothers] need assistance. They need guidance. I know there are some groups out there but it's difficult to know where. We don't know where all the resources are." (key informant 1).

Discussion

The study provided an understanding of how the occupational performance patterns of mothers of drug-dependent youth were influenced by their children's addictive behaviour. There is clear evidence that mothers were forced to adapt their roles, habits, routines and rituals.

Roles

The mothers' primary role of caregiver to their children was mostly affected. Also, the role of wife was affected negatively as mothers were not always able to communicate openly with their husbands. Further role adaptations were observed as mothers were often required to be fulltime caregivers for their grandchildren. Adopting the role of the "peace keeper" enabled the mothers to protect their children and keep them relatively safe, but this often negatively affected their other roles. Part of the peace keeper role was enabling or feeding the drug habits of their children. Mothers were faced with the situation whereby they were forced to allow theft, burglary, destructive behaviour and disrespect in their homes, as they felt this allowed them to monitor the behaviour of their

children and offer them a degree of protection. Sometimes the mothers kept information from their husbands, which could be regarded as leading to nuclear family triangulation[7].

Lewis[5] acknowledges the great financial burden faced by mothers (and families) of drug-dependent children. This was evident in the present study as many of the mothers were single parents and supported their families by having full time jobs; however, the mothers' ability to maintain effective worker roles and routines was altered by having to deal with their children's lifestyles. The financial burden on mothers was further compounded, as not only were the assets in the home vanishing, but the family's only income was now also used to indirectly support the young adult's drug habit.

Routines and habits

The mothers' routines became consumed by their drug-dependent children, who drew most of their focus, energy, attention and time. Sadly, this impacted on other family members, such as siblings. This can be likened to the challenges faced by parents of children with disabilities where the difficulties not only strain the relationship between the husband and wife, but also the relationship between the parents and their other children[18]. Mothers had to adapt their normal habits and adopt new habits to accommodate their children's addictive behaviours. Examples of new habits are where mothers were forced to place their money in their underwear to prevent their drug-dependent children from stealing their money, and hiding groceries away in locked containers and bedrooms so that their children could not steal and sell the groceries for money. These new habits were often adopted automatically and unconsciously by the mothers, and can be regarded as indirectly enabling their children's drug-dependence.

Rituals

With reference to rituals, attending church was a constructive coping mechanism which some of the mothers utilised. The spiritual benefits which the mothers received enabled them to continue to have faith and try their best to care for their children. However, often the mothers' ability to attend church was affected as they contemplated what risky behaviour their children might be engaging in whilst they were away. This extended to mothers' participation in social support networks with family and friends within the community. Clearly, the rituals of mothers were affected by the behaviours of their drug-dependent children, and this resulted in the mothers' occupational needs not being satisfied, thus interfering with optimal health and wellbeing.

Occupational performance

As a result of mothers' occupational performance patterns being affected by the addictive behaviours of their children, they experienced difficulty in performing optimally in their roles as mothers, wives, and workers. In support of this assumption, Max-Neef[19] in his theory of Human Scale Development acknowledges that through engagement in occupation, human needs are satisfied and these human needs include subsistence, protection, affection, understanding, participation, leisure, creation, freedom and identity. The mothers' difficulty performing their usual roles, routines, habits and rituals causes a deficit in their human development, and thus imposes on their occupational rights. The struggle by mothers to achieve optimal occupational performance as a result of the addictive behaviour of their children can result in occupational deprivation, imbalance and alienation[11].

According to Wilcock[11], in order to achieve health and wellbeing, 'doing' – or in this case engaging in the occupation of mothering – needs to provide meaning and purpose by, for example, boosting self-esteem, motivation and socialisation. In the case of the mothers in this study, this is not happening as they are prevented from engaging in many of their meaningful and purposeful occupations, and the innate characteristics of being a loving and nurturing mother are hindered. As a result, some mothers may contemplate or even resort to highly destructive behaviour as was the case with Ellen Pakkies.

LIMITATIONS

The main limitation of the study was the lack of diversity among participants. The mothers all belonged to the same ethnic, cultural and religious groups; and resided in poor socio-economic communities. There were two reasons for this. First, due to time constraints the study was only conducted at one rehabilitation center. Second, it was intended that the focus groups would comprise more participants, but this did not materialise as many mothers struggled to visit their children every week due to financial difficulties and the remote location of the center. Therefore, further research should be conducted with mothers from different backgrounds.

IMPLICATIONS FOR PRACTICE

A main concern mentioned by the mothers was that they were not aware of any services in their communities where they could seek advice, assistance or support. Similarly, the key informants indicated that they too were not aware of any community-based services for mothers of drug-dependent children. This indicates that support groups for mothers are either insufficient or non-existent, despite the dire need. Provincial leaders such as Helen Zille[6] have recognised this and advocated for community-based support groups for such mothers, but this requires resources, strategies and political will. Government officials, health professionals and citizens need to recognise the extent to which the occupational performance patterns of mothers with drug-dependent adult children are affected.

This study shows that essentially what mothers require is a place where they can relate their stories and share their experiences with other mothers. In this way, mothers would be able to learn vicariously from, and support, one another. It is also important that the mothers voice their concerns with professionals, in order to gain advice and assistance with regards to learning to detect and manage signs of drug-dependence in their adult children. They also need to know how to exercise tough love, manage stress, and relax while maintaining healthy relationships with their husbands, their other children, family members and friends.

CONCLUSION

In conclusion, the study identified how mothers' occupational performance patterns were affected by their drug-dependent, young adult children. Findings provided evidence that the mothers experienced occupational deprivation, imbalance and alienation from meaningful, purposeful roles, routines, rituals and habits. As the primary caregivers, the mothers were exposed to conditions which required them to adapt to deal with the behaviour of their children. This study highlights the need for supportive intervention for such mothers, which could address the adaptations required in their occupations as well as promote their wellbeing. Mothers should be enabled to face these challenges with assertion, in order to adapt their performance patterns in a more productive manner so they may continue to pursue their neglected roles as caregiver, wife, loving mother to other children, as well as returning to preferred routines, rituals and habits which will promote optimal occupational performance. However, there remains a need for further research in different contexts to deepen insight into the influence of addictive behaviour on the occupational performance of mothers, as well as other caregivers.

REFERENCES

1. Plüddeman A, Parry CDH. Methamphetamine use and associated problems among adolescents in the Western Cape Province of South Africa: A need for focused interventions. South African Medical Research Council, Policy Brief, October 2012. <http://www.mrc.ac.za/policybriefs/Methamphetamine.pdf> (12 February 2014).
2. Dada S, Plüddemann A, Parry CD, Bhana A, Vawda M, Fourie D. Alcohol and drug abuse trends: July - December 2011. South African Medical Research Council, 2012.
3. Samodien L. Pakkies goes free. Cape Argus, p.1. 11 Dec 2008.
4. Thangvelo, D. Tikked off. Cape Argus, p.1. 26 April 2010.
5. Lewis, E. More blacks turn to tik and heroin, but help is scarce. Cape Argus, p.8. 31 May 2010.

6. Helen Zille on South Africa's horrific drug epidemic. <http://www.politicsweb.co.za/politicsweb/view/politicsweb/en/page71651> (13 June 2011).
7. Pinheiro RT, Pinheiro KAT, da Silva Magalhaes PV, Horta BL, da Silva RA, Sousa PLR, Fleming M. Cocaine addiction and family dysfunction: A case-control study in Southern Brazil. Substance Use and Misuse, 2006; 1: 307-316.
8. Gerdes L, Louw A, van Ede D, Louw D. Early and middle adulthood. In: Louw DA, van Ede D, Louw A, editors. Human development. 2nd ed. Cape Town: Kagiso Tertiary, 1998: 386.
9. Hoghughi M, Nicholas M. Handbook of parenting: theory and research for practice. London: SAGE Publications, 2004: 66-67.
10. Helbig K, McKay E. An exploration of addictive behaviours from an occupational perspective. Journal of Occupational Science, 2003; 10(3): 140-145.
11. Wilcock AA. An occupational perspective of health. 2nd ed. Thorofare, NJ, USA: Slack Incorporated, 2006.
12. Wegner L. Through the lens of a peer: Understanding leisure boredom and risk behaviour in adolescence. South African Journal of Occupational Therapy, 2011; 41(1): 18-24.
13. Primeau LA. Divisions of household work, routines, and child-care occupations in families. Journal of Occupational Science, 2000; 7(1), 19-28.
14. Primeau LA. Household work: When gender ideologies and practices interact. Journal of Occupational Science, 2000; 7(3), 118-127.
15. American Occupational Therapy Association. Occupational therapy practice framework: Domain and process. American Journal of Occupational Therapy, 2008; 62(2), 625-683.
16. Finlay L, Gough B. Reflexivity: A practical guide for researchers in health and social sciences. USA: Blackwell Publishing, 2003.
17. Henning E. Finding your way in qualitative research. Pretoria: Van Schaik Publishers, 2008.
18. Copp M. "Special needs: Does a disabled child equal disabled family?" <http://www.babiestoday.com/articles/special-needs/does-a-disabled-child-equal-a-disabled-family-4321> (24 August 2010).
19. Max Neef MN. Sociology: A global introduction. London: Prentice Wall, 1991.

❑

Corresponding Author
Lisa Wegner
lwegner@uwc.ac.za

The prevalence of burnout amongst therapists working in private physical rehabilitation centers in South Africa: a descriptive study

Theresa Du Plessis, BA Social Work, MPhil Rehab
Social worker - Life, The Glynnwood Hospital, Benoni

Surona Visagie, B.Sc Physiotherapy, M.Sc Rehab
Extra-ordinary senior lecturer, Centre for Rehabilitation Studies, University of Stellenbosch

Gubela Mji, B.Sc Physiotherapy, M.Sc Rehab (UCT), PhD
Director Centre for Rehabilitation Studies, University of Stellenbosch

ABSTRACT

Health care service providers are at risk of burnout due to the nature of their jobs and their personalities. No research has been published on the prevalence and causes of burnout in therapists working in physical rehabilitation units in South Africa. This study aimed to determine the prevalence of burnout and identify causes in therapists working in physical rehabilitation in South Africa.

A descriptive, quantitative study was done. Study participants comprised 49 therapists (14 occupational therapists, 13 physiotherapists, 7 therapy assistants, 4 social workers, 1 dietician, 5 speech therapists and 5 psychologists) from six private rehabilitation units in South Africa. No sampling was done. The prevalence of burnout was established with the Maslach Burnout Inventory Manual (MBI). Demographic and employment data were gathered through a questionnaire. MBI scores were categorised as high, moderate or low on the subscales of emotional exhaustion, depersonalisation and decreased personal accomplishment. The maximum likelihood and chi-squared tests were used for statistical analysis. A p value of <0.05 was deemed statistically significant.

The prevalence of burnout was high: 57.14% suffered from emotional exhaustion, 20.40% from depersonalisation and 38.77% from decreased personal accomplishment. Not having children ($p = 0.029$), poor coping skills (0.031), an overwhelming workload (0.039),and poor work environment (0.021) had a statistically significant relationship with emotional exhaustion. An overwhelming patient load (0.012), seldom achievable deadlines (0.036), postponing contact with patients (0.02) and poor work environment (0.04) had a statistically significant relationship with depersonalisation. Male gender (0.023), not having children (0.038), less than four years of tertiary education (0.036), low income levels (0.022), high administration load (0.003) and postponing contact with patients (0.011) had a statistically significant relationship with personal accomplishment.

Ensuring on-going support emotional support and job satisfaction of therapists is important if an institution is to provide continuing quality rehabilitation services.

Key words: Burnout, therapists, physical rehabilitation

INTRODUCTION

Due to the nature of their work health care service providers are at risk of burnout. However, research on the prevalence and causes of burnout amongst health care service providers in South Africa is scarce[1]. Those studies that have been done focussed on nurses practising in acute, public health care settings[2,3]. No South African study on burnout amongst therapists from a private or public health care setting could be found. The primary author of this article was employed as a social worker in a private physical rehabilitation facility in South Africa. She noticed that staff members often complained about stress in the workplace. She recognised some of the signs and symptoms of burnout in their complaints. Thus she embarked on the study to determine the prevalence and possible causes of burnout in private, physical rehabilitation units in South Africa.