

Exploring the history of Occupational Therapy's development in South Africa to reveal the flaws in our knowledge base

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ABSTRACT

This article 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. It was flawed by virtue of its origins within a Eurocentric, paternalistic and male dominated health milieu under the influence of the medical model and by virtue of the unnatural, oppressive nature of governance at the time. Flawed because it inadequately collaborated with disabled people, Africans and South African Indians both in the design of curricula and research.

Using a qualitative design with a substantial and broad set of data sources, this research attempted to expose these flawed layers and to explore how they impacted on the epistemology of South African occupational therapy. It is proposed that the method employed for reviewing both the scope of practice and its practitioners could bring into being more appropriate South African occupational therapy education in the future.

Key words: Epistemology, historical review, changing face of occupational therapy, discourse, indigenous knowledge

Introduction

Embarkation upon this research was significantly cathartic for the author in that it necessitated deep and sometimes painful interrogation of her ancestral roots and how these and other influences have impacted upon her own personal life-development and the development within her vocation and career as a white female occupational therapist in South Africa during the apartheid and post-apartheid years. It has caused her to question those tracts of development that both she and respected, committed colleagues, have plotted out and followed, without ulterior motive and with good intention, over the past 50-odd years of occupational therapy's history in this country. It became a challenging process of exploring how the roots, rivers, valleys and mountains of our backgrounds, thoughts and knowledge systems occurred.

Because of the particular historic-political South African 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 focused on issues of power, discourse, suppressed voices, and historical context. Feminism, Foucault and, to some extent, critical theory, were selected as analytical theoretical frameworks because they facilitated a deeper and more revealing exploration of occupational therapy's epistemology in this country.

During the analysis of the first sets of data coupled with ongoing reflections, meetings and interactions with colleagues, there emerged a growing uneasiness and a realisation that exploring occupational therapy through a new and different lens could convert what had originally been so 'familiar' to the author into something which became 'unfamiliar' and as such create a new and provocative perspective into the South African occupational therapy epistemology as it emerged from its historical roots.

In addition, analysis and engagement with various data sets made the author 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, and more particularly, to incorporate essential South African ingredients in order to form this identity. There was also a need to reach consensus amongst South African occupational therapists about the key and core philosophical constructs that underpin this identity.

Attempts at articulating an identity and philosophical framework for occupational therapy in South Africa in the past 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, shared values are central in this linguistically, ideologically and historically embedded project we call science¹. The author contends that a Eurocentrically biased science forms the foundation upon which the South African occupational therapy curriculum was built.

Mocellin² maintains that occupational therapy models have been developed exclusively in the Western world and Kortman³ questions how appropriate these models are to other cultures. Kortman further states that models are culturally bound and 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. Iwama⁴ maintains that cultural comparisons of models not only enable a deeper understanding of the structure and language of models but can also raise hidden aspects within models to what he refers to as "new possibilities of insight and application"^{4:221}. In addition, Hudson⁵ suggests 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.

Influences and developments taking place in the rest of the world are important and should be acknowledged: globalisation, information technology and air travel have concertinaed the world's

Autoethnography - 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)



continents, making access to each others' knowledge, within seconds or hours, possible. It would therefore be both naïve and foolish not to prepare South African occupational therapists to be able to work anywhere in the world. It is however of foremost importance that they are competent in dealing with the particular health needs of South Africa's diverse population where the need for appropriate health care is greatest.

Given the diversity of cultures and races in South Africa, and indeed in most cosmopolitan countries today, the profile of the occupational therapy profession begs the question:

"how do the 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?"^{4,18}

In addition, and largely because of historical influences many occupational therapists throughout the world still have a preoccupation with, and embeddedness within, the positivist, reductionist medical model of health care. This, coupled with an apparent lack of concerted effort to adequately engage with the disability activist discourses occurring around other more appropriate models has, in my opinion, alienated us from the very people we should be serving i.e. people with disabilities. The profession would achieve more if it empowered 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 others⁶.

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 the life of a person who has an impairment, there is a professional counterpart situated either within a profession or voluntary organisation. 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^{6:11} puts it, "...far from being detached from the lived 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." This is a particularly significant statement because it clearly demarcates and positions us as being in an oppositional camp to that of people with disabilities. Hammel⁷ suggests that rehabilitation professionals accept uncritically an ideology of normality e.g. normal posture, normal writing patterns, which reflects dominant standards and values and these become the norms to which everyone must conform. These ideological underpinnings are reflected in the classification systems we use which further reinforce specific power dynamics. Masasa⁸ in research to determine the knowledge and attitudes towards disability of caregivers in Lesotho, concluded that health professionals should be culture sensitive and have respect for the beliefs and value systems of their clients if they are to afford appropriate, early intervention.

South Africa's infamous history and the emerging democracy has necessitated the 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 interpretation of practices that are alternative to those traditionally associated with the profession⁹.

Studying the development of a profession from an historical perspective may suggest factors behind the evolution, survival or demise of past characteristics of the profession and hence, perhaps, of the characteristics that will be required in the future¹⁰. Such factors alert the historicist within us to trends and cycles from the past that have influenced change and the fixations of these that have

possibly resulted in inertia. They also reveal how unique and often random occurrences can channel events¹⁰.

Methods

Using a form of autoethnography the researcher's reality within this research essentially took 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 her version of the truth as revealed through her interpretation of the data.

Thus, coupled with a qualitative research approach, the author locates herself within the developing world of occupational therapy in South Africa and uses material and interpretative practices that will make this world more visible¹¹ and, hopefully, more meaningful.

The research was essentially a theoretical exploration of the development of the profession of occupational therapy in South Africa, using a range of conceptual arguments which takes the reader through a bricolage¹¹ of different perspectives and revelations. This resulted in evocative and provocative reasoning which the researcher feels will be essential in emancipating the profession from an historical bondage that has reined in its potential to run free and become its own.

During most of the stages of data gathering a predominantly theoretical sampling process was used in which the data was collected for generating theory. The researcher collected, coded and analysed the data and as the theory emerged from each set of data¹² it informed her decision about what data to collect next. 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 many opportunities arose during the process, which were too good to lose. For example, opportunities to bounce developing thoughts off others and gaining opinions about these thoughts, or listening to some of the relevant voices of different people who represent some of the complexities present in this country.

Data sources: data gathering occurred in three basic phases (see *Table 1* on page 23).

Phase one

The original aim was to explore the broad occupational therapy curriculum in South Africa to establish whether it was meeting the health needs of its people given the changes that had taken place since (or before) 1994.

The **first set of data** in this phase consisted of documentation related to the education of occupational therapists from all eight training Universities*. These were analysed using grounded theory and the results of the analyses were then used to formulate core questions for focus groups in order to more deeply investigate aspects that had not clearly revealed themselves in the first set of data.

The **second set of data** was obtained from the results of four focus groups with both clinical and academic therapists, held in four different provinces of South Africa. For selection of the participants in these groups the researcher requested that the various centers at which they occurred assisted by inviting participants who represented diversity in terms of age, race, fields of practice and teaching. Their perceptions were probed to establish if they thought that the existing training of South African occupational therapists was appropriate.


Finally in this first phase, the results of the analysis of data sets one and two were sent electronically to a group of pre-selected academic and clinical OTs from various parts of South Africa. This was referred to as a Resonance Group (**data set three**) as it became a sounding board for opinions on the first two data sets.

* These were the first set of curriculum submissions requested of OT training centres by the South African Qualifications Authority, in order to commence the process of quality assurance in the training.



Table 1: Phase One — Data Sources

(The black arrow on the table below indicates the point at which the focus of research changed. This table represents the phenomenological phase of data gathering.)

DESCRIPTION OF DATA AND SEQUENCE	SOURCE OF DATA	PURPOSE FOR WHICH IT WAS GATHERED	INFLUENCE UPON EMERGING THEORY
Phase One			
Data set one SAQA Submissions	All 8 universities training occupational therapists in South Africa.	To draw up a profile of the final competencies expected of qualifying OTs.	Guided some of the core questions for the focus groups
Data set two 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 OTs 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.
Data set three Resonance group feedback	A group of 12 OTs 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.
Data set four Statistics of OTs registered with the HPCSA in Oct.2004	Health Professions Council of SA	To establish the current demographic profile of OTs in SA.	Confirmed the dominance of white females. 

The first 3 sets of data, together with an analysis of the Health Professions Council of South Africa's statistics of registered therapists — **data set four** — (used to determine racial and cultural diversity of therapists currently registered to work in South Africa), was the turning point at which the detour away from the phenomenological theoretical framework took place.

These four sets of data became pivotal in contributing to the first part of an emerging theory by providing evidence of the dominance of *medical model and Eurocentric* ideology in the occupational therapy epistemology. This emerging theory suggested that it was essential to explore relevant historical documents in order to establish how the socio-political milieu of the origins of occupational therapy in South Africa impacted upon its epistemology.

Phase two:

Data set 1: Relevant historical documents from the apartheid years were collected, for example, the regulations defining the role and scope of occupational therapy, regulations related to practice, historical records of the development of the OT professional association in South Africa and various journal articles written in the early editions of the South African Journal of Occupational Therapy. These documents were used:

- ❖ To explore the development of occupational therapy in South Africa in order to establish factors that had impacted upon the epistemology. This also included a comparison between the number, gender and race of therapists registered with the HPCSA to establish if the past profile of predominantly white females had changed before and after 1994.
- ❖ To explore relevant past policy and legislation during the time of the early development of occupational therapy in order to establish sources of power which influenced this epistemology and compare these against current, relevant government policy, legislation and attitude.
- ❖ 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.

The juxtaposition of past and present legislation pointed 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 later data production strategies.

Apart from providing valuable historical information many of the old South African Occupational Therapy Journals also revealed the paternalistic discourse of those times and further contributed to the emergence of the theory of patriarchy over occupational therapy's epistemology.

The Revised Minimum Standards for the Education of Occupational Therapists of the World Federation of Occupational Therapists¹³ was used for a global comparison of training standards.

Data set 2 consisted of stories of people with disabilities. Based upon personal recollections from discussions with disabled activists in South Africa, and during the process of the literature review for this research, 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 (Finkelstein⁶, Hammel⁷, Finkelstein^{14a}, Finkelstein^{15b}, Jagoe¹⁶, Miles¹⁷, Shakespeare and Watson¹⁸, WHO^{19a,20b}, Oliver²¹, Barnes and Mercer²² and Masakhwe²³).

Hence the need 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, 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 community entry with the community leaders of that area in the early 1990's in order to use its resources for student training, and 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. (See Table II)

The following extract from "Sam" one of the subjects interviewed for this research, expresses his opinion on some of the rehabilitation professionals who were involved in his rehabilitation.

"But some of us when we come out of school and we get told that what we've been doing at school it was a waste (waste) of time. I think that some of the people that work in (special) schools they don't really believe in us. They think that when we live (leave) school we should go home and be a part of the furniture. But if they do not believe that a

disable person can make something with they (their) lives they should not work with us. (And later in discussing his experiences of rehabilitation he says)... when I first went to school they wanted to kick me out just because they thought I was too disabled. They just looked at my disability not at my brain. Luckily my first teacher saw that I had a good working mind and she Ashley (actually) cried so they wouldn't kick me out. I mean if we get kicked out of the schools that we suppose to get help from where do they expect us to go...?. 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".

The revelations

The revelations of this research were both traumatic and exhilarating for the researcher and I have tried to summarise them in the following analogy which I hope will reveal their findings in a more interesting and novel manner.

The coming of age of the profession of occupational therapy in South Africa is a contentious one, 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.

White male doctors, who were often trained abroad, imported

Table 11: Phase Two — Data Sources

This table 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
Phase Two			
Data Set One 1. Historical documents	<ul style="list-style-type: none"> - Davy's (2003) document on the first 50 years of OT in SA. - old SAMDC rules and 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. 	<p>To explore historical influences upon the development of OT in South Africa and how these are impacting upon the current course the profession of OT is taking</p> <p>These volumes were used for comparative purposes to study the disability discourses of Governments then as opposed to now.</p> <p>To substantiate and confirm and compare ideological influences impacting upon SA OT development</p>	<p>Confirms the strong influence of medical model ideology and the power exerted by patriarchal control systems of the day.</p> <p>New insights lead to new data production strategy.</p> <p>Confirms the oppressive, racially biased, apartheid ideological attitudes and power structures used as the voices of people with disabilities</p> <p>Served to demonstrate some strong parallels and similarities between global and local development of OT</p>
2. Post apartheid government documents	<ul style="list-style-type: none"> - Current HPCSA 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. 	<p>To allow for comparisons between then and now and how the focus of health care in South Africa has changed.</p>	<p>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</p>
Data Set two Life stories of people with disabilities	<ul style="list-style-type: none"> - Various Articles and Chapters written by disability activists and rights movements. - 2 life stories of relatively young men from economically and, previously politically disadvantaged, backgrounds. 	<p>To gauge the perceptions of people with disabilities about the attitudes and quality of care they receive from health professionals.</p> <p>To explore the lives of two people with disabilities who became disabled during the apartheid era and would thus have had/ not have had exposure to the health and rehabilitation services of that time.</p>	<p>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 heightened awareness of what needs to be changed to make the OT contribution more acceptable and meaningful.</p> <p>Heightened awareness of mistakes of our past and some of our current interventions.</p>



British trained occupational therapists to start the training of occupational therapists in South Africa. For the first 22 years of the OT Association's History, it was chaired by a male medical doctor or psychiatrist²⁴ who basically dictated what OTs should or should not be allowed to know and do.

Some extracts from the History of SAAOT²⁴

1958/59: "Honorary life membership was conferred upon the past 5 presidents of the Association" [with the exception of Mr P, this meant honorary life membership for all previous presidents of the Association since its inception in 1945 who were medical doctors/psychiatrists]

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.XYZ. (Orthopaedic Surgeon)

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

[It seems extraordinary that the new constitution should again have to be formulated by a medical doctor (1)]

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

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

[The words (1) in this history 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.]

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.

Pillay²⁵ in discussing the history of Speech-Language therapy and audiology in South Africa, which has many parallels with occupational therapy, refers to the allegiance or affiliation with male-centred ways of knowing, male epistemologies and male ideologies as a form of androcentrism, he reveals the male-dominated influences on training of a predominantly female profiled profession 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.

The historical background on the conception of occupational therapy in South Africa 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 introducing the now infamous system of apartheid. 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. Legislation under the apartheid Government and the South African Medical and Dental Council ensured this. According to the Medical, Dental and Supplementary Health Services Act 56 of 1974 (as amended: 753)²⁶, in chapter 1 which describes the "Continued Existence and Objects, Functions and Powers of the South African Medical and Dental Council(SAMDC)". For the purposes of this article, I will discuss here only two examples of these to give the reader an idea of the control over our knowledge and the hegemonic discourse used. Under the section describing the Objects, Functions and Powers, of the council most significant are:

"3(b) ...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 "

It is important to note here that in the 1970's the membership of the Council of the SAMDC was as follows: 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 therapy.

Thus, 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 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"²⁶.

Quote from resonance group:

Respondent 2: My overall comment is that Annexure 1 [commenting on the findings from my analysis of the SAQA submissions] is using terminology that is entrenched in the medical model. Terminology such as "treatment", physical and/or psychiatric disorder", "patient population". 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. OTs are working outside the health sector more and more

Extract from focus group:

Participant X: But I think people are scared to make the shift. ... I think there's still quite a bit of people (meaning OTs) who feel comfortable in the medical model ...

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 population was superficial and abnormal, therefore her understanding of them was also superficial and abnormal.

It is hardly likely that occupational therapists practising in the apartheid era deliberately marginalised and oppressed those individuals of other race groups that they served. I am sure that their intentions were honorable and based upon a genuine need and desire to help those they served. 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 of occupational therapists difficult and was in itself a recipe for oppression and marginalization.

Extract from focus group:

Participant Y: "...um I think we've become much more patient centered ah with an emphasis on the client's needs, empowering the client rather than this maternalistic type of approach that you generally have (had).... I also think there's been a shift from... from... hospital.... out of hospital into communities..... 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....."

Consequently the child 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.

Charlton²⁷ 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 mobilising 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.

Conclusion

The purpose of this research was to expose and explore occupational therapy's 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 or their effects.

I believe the child is coming of age and at a stage now when s/he has used her/his resilience to really change those flaws of the past and is now recreating a new and more robust and appropriate Africanised epistemology. I stand with bated breath on the threshold of my departure from the profession and trust that I am right!

References

1. Lather, P. Post-modernism and the human sciences. In: Kvale, S. (Editor). *Psychology and post-modernism*. London: Sage, 1991.
2. Mocellin, G. An overview of occupational therapy in the context of the American influence on the profession. *British Journal of Occupational Therapy*, 1992; 55(1): 7- 8.
3. Kortman, B. The eye of the beholder. *Australian Journal of Occupational Therapy*, 1994; 41: 115-122.
4. Iwama, M. Situating occupational therapy's meaning. In: Iwama, M. *The Kwa Model: Culturally relevant occupational therapy*. Edinburgh: Churchill Livingstone, 2006.
5. Hudson, B. Holding complexity and searching for meaning: Teaching reflexive practice. *Journal of Curriculum Studies*. 2002; 34(1): 43-57.
6. Finkelstein, V. *Attitudes and Disabled People*. Monograph No 5. New York: World Rehabilitation Fund International, 1980.
7. Hammel K. W. *Perspectives on disability & Rehabilitation: contesting*

assumptions. New York: Elsevier, 2006.

8. Masasa, T. Irwin-Curruthers, S. & Faure, M. Knowledge of beliefs about and attitudes to disability: implications for health professionals. *South African Family Practice*, 2005; 47(7): 40-45.
9. Duncan, M. Buchanan, H. & Lorenzo, T. Politics in Occupational Therapy Education: A South African Perspective. In: Kronenberg, F. Algado, S. & Pollard, N. (Editors) *Occupational therapy without borders – Learning from the spirit of survivors*. Edinburgh Elsevier-Churchill Livingstone, 2005.
10. Cocks D. "The role of history in future gazing". A talk to the Independent Scholars Association of Australia. <[<http://www.labshop.com.au/dougcocks/ISAAtalkhntn\(1999\)](http://www.labshop.com.au/dougcocks/ISAAtalkhntn(1999))> Accesse3d 12/12/04
11. Denzin, N. & Lincoln, Y. Introduction: The discipline and practice of qualitative research. In: Denzin, N. & Lincoln, Y. (Editors). *Collecting and interpreting qualitative materials*. London: Sage, 2003.
12. Glaser, B. & Strauss, A. Theoretical sampling. In Glaser, B. & Strauss, A., *The discovery of grounded theory – Strategies for qualitative research*. Chicago: Aldine Publishing Co. 1967.
13. World Federation of Occupational Therapists. *Revised Minimum Standards for the Education of Occupational Therapists*. Published by WFOT, P.O.Box 30, Forrest field, Western Australia, 2002.
14. Finkelstein, Disability and the helper/helped relationship. An historical view. In: Brechen, A. Liddiard, P. and Swain, J. (Editors). *Handicap in a social world*. London: Hodder & Stoughton, 1981a.
15. Finkelstein, V. *Disability and professional attitudes*. The Open University, RADAR Conference Proceedings. NIADEX '81, 21-24 October, 1981b.
16. Jagoe C. Condemned to Live. *Disabled People South Africa*. Bulletin: circa 1984: 2.
17. Miles, S. Engaging with the disability rights movement: the experience of community-based rehabilitation in Southern Africa. *Disability & Society*, 1996; 11(4): 501-517.
18. Shakespeare, T & Watson, N. Defending the social model. In: Barton, L. & Oliver, M. (Editors). *Disability studies: Past, present and future*. Leeds: The Disability Press, 1997.
19. World Health Organisation. Rethinking Care from the Perspective of Disabled People: A new WHO report. August Conference Report and Recommendations: Disability and rehabilitation Team. <http://www.who.int/inf-pr-2001/en/note2001-16.html> (2001a) Accessed 1/21/05.
20. World Health Organisation. *Rethinking Care from the perspective of disabled people*. Conference reports and recommendations. WHO Disability and Rehabilitation Team. August 2001b.
21. Oliver, M. Using emancipatory methodologies in disability research. 1st Annual Disability Research Seminar. The National Disability Authority and the Center for Disability Studies. University College. Dublin. www.leeds.ac.uk/disability-studies/archiveuk/index. (2002). Accessed July 2004
22. Barnes, C. and Mercer, G. *Implementing the social model of disability: Theory and research*. Leeds: The Disability Press, 2004.
23. Masakhwe, P.W. African conflicts and the disability toll. *Disability World*, No 24. June. <http://www.disabilityworld.org>. (2004). Accessed 22/9/04.
24. Davy J. *The History of the Occupational Therapy Association of South Africa*. OTASA Office. Box 11695, Hatfield 0028 RSA. (2000).
25. Pillay, M. (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. University of Durban-Westville. Durban, 2003.
26. 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.
27. Charlton, D. The argument. In: Charlton, D. *Nothing about us without us: Disability oppression and empowerment*. Berkeley: University of California Press, 1998.

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