

**THE EXPERIENCES AND PERCEPTIONS OF INDIVIDUALS WITH
STROKE ABOUT THE USEFULNESS OF THE MODEL OF
OCCUPATIONAL SELF EFFICACY IN A RURAL SETTING**

**A THESIS SUBMITTED IN FULFILMENT OF THE REQUIREMENT OF
THE DEGREE MAGISTER SCIENTIAE (OCCUPATIONAL THERAPY)**



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DECLARATION

I, Melissa Smith, declare that the work on which this thesis: *The experiences and perceptions of individuals with stroke about the usefulness of the model of occupational self-efficacy in a rural setting*, is my own original work (except where indicated otherwise), and that it has not previously or in its entirety or in part been submitted for a degree at this or any other university.

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ABSTRACT

Individuals diagnosed with stroke particularly in rural communities have a poor return to work rate. Vocational rehabilitation has been used as an intervention strategy with various types of clients with disability or injury in order to improve their work skills. The aim of the proposed study is to describe the experiences and perceptions of individuals diagnosed with stroke about the usefulness of the Model of Occupational Self Efficacy in assisting them in returning to their worker role particularly in a rural setting. Eight participants were purposively selected from the data base of a local hospital and semi structured interviews were conducted with the participants until saturation occurred. Furthermore, two focus groups were conducted with eight participants. A key informant was also interviewed to assist the researcher with a different perspective and to avoid bias. The data was analysed by means of thematic analysis into codes, categories and themes. Trustworthiness was ensured by means of credibility, applicability, transferability and conformability. Informed consent and confidentiality was ensured. Permission was obtained from the UWC research committee and from the Department of Health.

Four themes were merged from the findings: **Theme one:** Obstacles which affects the return to work of CVA Participants in a rural community. **Theme two:** Establishing a strong belief in functional ability through occupation. **Theme three:** Adaptation strategies that enhances the work participation of stroke survivors in a rural community. Finally **Theme four:** The MOOSE enables transition to the worker role in a rural context. The findings revealed that the participants experienced a loss of their former self thus affecting their worker identity as they were no longer able to experience the gratification of fulfilling their worker role. This was due to the participants not being aware of the return to work options that they had. After the stroke the participants battled

with not only overcoming their condition but also the stigma which the community and their employers had of stroke. Overcoming the stroke event and returning to work required that potential barriers and facilitators be identified by the participants and the researcher. The study also identified adaptation strategies that the participants utilised in order to overcome the barriers and assist the participants to have a smoother transition into the workplace.

In conclusion the findings of the study revealed that the participants suffer a loss of their former abilities and undergo a loss of their self-esteem. As a result of the loss, participants struggled to return to work not only due to their loss of abilities but also their lack of knowledge regarding return to work and stroke. The findings indicated that there should be more education regarding the stroke that needs to be conducted in communities via media such as local newspapers, local radio stations, clinics and hospitals. The findings of the study may assist Occupational Therapy practitioners to improve services in a rural community for stroke survivors and improve the facilitation of the return to work process after stroke. The MOOSE facilitates motivation for participants to regain their self-esteem and thus move forward to resume a worker role.

Keywords: Stroke, rehabilitation, perception, occupation, disability, vocational rehabilitation and supported employment.

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First and foremost, I give praise and thanks to my Almighty God for granting me the opportunity, wisdom and ability to complete this research study.

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To my late grandmother Patricia Elaine Smith: Thank you for the sacrifices made for our family and for motivating me to aim high. Without you I would not be where I am today or have the opportunities I have today. I wish you had lived to see me graduate.



LIST OF ACRONYMS

BMREC	Biomedical Research Ethics Committee
CVA	Cerebral Vascular Accident
DSM-V	Diagnostic and Statistical Manual of Mental Disorders
EEA	Employment Equity Act
GCS	Glasgow Coma Scale
IPR	Interpersonal Relationship
MOHO	Model of Human Occupation
MOOSE	Model of Occupational Self Efficacy
PWD	Persons with Disabilities
RTW	Return to Work
SASSA	South African Social Security Agency
SE	Supported Employment
WHO	World Health Organisation



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CHAPTER ONE: OVERVIEW OF THE STUDY

1.1 Background

During the course of the researcher's work as an Occupational Therapist at Abraham Esau Hospital in Calvinia, many patients after their stroke (CVA) rather preferred to attain a disability grant than to return to work. The Occupational Therapy Department would offer rehabilitation and assessment but after an average of 3 sessions they would default and not return to therapy. The researcher observed when patients attend therapy they would enquire about disability grants, also known as SASSA grant in the community. According to Statistics South Africa (2011), in the Northern Cape there are 52,789 persons utilizing the disability grant. As stated by the United Nations (2015), state parties should accurately identify the correct persons with disabilities who could return to work, the United Nations report further stipulates that State parties should promote the recognition of the right of PWD to return to work, including for those who acquire disability during the course of employment. The researcher wanted to assist the Department of Occupational Therapy to improve the return to work statistics. It is of great concern as many of the client's assessed in the unit were bread winners of the household. To further explore the challenges individuals diagnosed with a stroke experienced when returning to work after they participated in the Model of Occupational Self Efficacy. The study explored the participant's motives and their fears about returning to work in the rural setting of Calvinia.

1.2 Introduction

A stroke, also known as a cerebrovascular accident (CVA), occurs when the blood flow to the brain is interrupted. This could either happen when a blood vessel to the brain ruptures, causing bleeding, or becomes blocked by a blood clot. The affected brain cells then start to die due to a lack of oxygen and other nutrients. The severity of a stroke varies from a passing weakness or tingling in a limb to a profound paralysis, coma or death (Steyn, 2006). According to the World Health Organization (2016), stroke is the leading cause of disability in the world. In South Africa, stroke accounts for between 8-10 percent of all reported deaths and it is among individuals in their prime working ages. In addition to the mortality rates, stroke results in an effect on disability (WHO, 2016).

According to O’Neill et al. (2002), strokes have been found to have a significant impact on an individual’s function and often results in disability. Examples of disability are an individual’s inability to engage in activities such as dressing and cooking due to functional limitations. In rural settings the effect of disability on an individual’s function becomes more difficult and the environment does not necessarily have the physical structures to assist the individuals, such as ramps and elevators (O’Neill, Dornan, & Denning, 2002). Kruger and Nel (2006) highlighted that the inclusion of persons with disability in the assumed “normal” society is a complex concept as not many of them are viewed in the same light with regards to capability by the “normal” society members. Persons with disability are often found on the fringes of the communities and are excluded from day to day occupations (Kruger & Nel, 2006) . The United Nations (2015) goes further to suggest that PWD are the world’s largest minority, as persons with disability make up 10 percent of the world’s population (The United Nations, 2015). To bring this closer to home, and in a South African context, according to the South African census done in the year 2011, the

findings revealed that the National disability prevalence rate was 7.5 percent (Statistics South Africa, 2011).

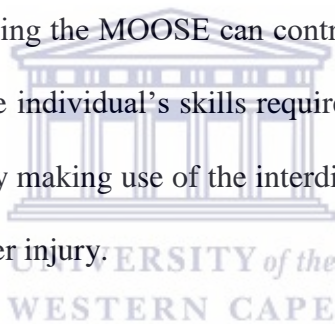
Calvinia is approximately 400 km from Cape Town, Springbok, Upington and Beaufort West. The population of Calvinia is 20 000 people who live and work in towns, in and around the Hantam District. The Hantam district covers approximately 30 000 square kilometers and includes Calvinia (the centre) as well as Brandvlei, Loeriesfontein, Middelpoort and Nieuwoudtville. Seventy per cent of the population, of approximately 20 000 people live and work in the towns. Farming is the main contributor to the economy, namely sheep, wool, Lucerne as well as rooibos tea. Between the working ages of 15-65 years, the percentage of people employed are 64.3 percent in the area, with an unemployment rate of 11.8 percent (Statistics South Africa, 2011).

1.3 Rationale

In an effort to combat the challenges which persons with disabilities face with regards to returning to work, the Employment Equity Act (EEA) of 1998, has created policies and several laws to address disability concerns in vocational settings. The Employment Equity Act is based on the premise of equal opportunities for all persons with disability in the employment market. The Department of Labour provides a monetary incentive in the form of tax rebates to appeal to medium and large companies in order to employ persons with disabilities (Employment Equity Act of 1998, online, 2015). In spite of these incentives there are only a small fraction of people with disabilities who are currently working after they have been injured with the minimal possibility of returning to work. According to James (2012), rural communities suffer significantly from injustices. According to Ball et al. (2006), the low employment rate after injury or a condition such as a stroke has fuelled poverty rates in rural areas. Once an individual has suffered an injury, the employee

feels intimidated to return to work, knowing the stigma attached to disability in the work place. This causes anxiety and heightens the person with disability to apply for a disability grant. Therefore, it is crucial to empower employees in these communities so that they can obtain a better quality of life. (James, 2012).

The Model of Occupational Self Efficacy Model (MOOSE) developed by Soeker (2009), focuses on improving the work skills and enhance the return to work process of individuals with traumatic brain injury. As a result of this model being flexible and being able to adjust to different contexts would prove to be beneficial in improving the work skills of individuals diagnosed with a stroke. The MOOSE has a holistic approach to rehabilitation and takes into consideration all spheres and areas of the individual's life. Utilising the MOOSE can contribute to the individual's motivation to return to work, by enhancing the individual's skills required for the job, through remediation, compensation and rehabilitation, by making use of the interdisciplinary team, thus improving the perception of returning to work after injury.



1.4 Problem Statement

The motive for the study is linked to the lack of research regarding the perceptions and experiences of individuals with disability about returning to work specifically focusing on individuals in a rural community setting. The literature which was found is centralised around the individuals in the more established communities, where there are rehabilitation centres and resources that are much more easily accessible, as well as facilities which offer enabling of skills training and retraining. In a rural setting it is more difficult to have an individual with a disability return to work, because of the stigma attached to disability and the misconception that a person with disability will slow down production and result in product and project failure. As a result of the lack of education

around disability, persons with disabilities accept these perceptions to be true. This affects their self-esteem and the way in which they view their ability to perform their work roles and skills. According to Coleman et al (2013), discrimination of disabled people in the work place can take place in the form of; the types of work that is given to persons with disabilities, being ignored and work load. The authors elaborate further and state that often unfair treatment in the workplace against persons with disabilities are related to being given fewer responsibilities that they had wanted (Coleman, Sykes, & Groom , 2013).

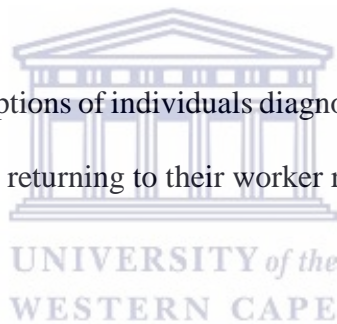
The current study will therefore explore the experiences and perceptions of stroke. The survivors about returning to work after they participated in a vocational rehabilitation model.

1.5 Research Question

What are the experiences and perceptions of individuals diagnosed with stroke about the usefulness of the MOOSE in assisting them in returning to their worker role particularly in a rural setting?

1.6 Research aim

The aim of the study is to describe the experiences and perceptions of individuals diagnosed with stroke about the usefulness of the MOOSE in assisting them in returning to their worker role particularly in a rural setting.

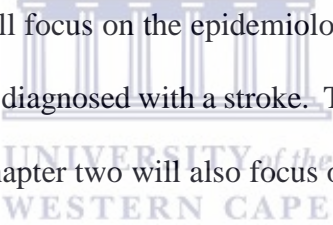


1.7 Research Objectives

- To describe the experiences and perceptions of individuals with stroke regarding the usefulness of the MOOSE in facilitating the transitioning to their work role.
- To describe the experiences and perceptions of individuals with stroke about how their worker identity has changed after participating in the MOOSE.
- To describe the experience and perceptions of individuals living with stroke about how the MOOSE enabled them to adapt to their worker role in a rural setting.

1.8 Overview of Subsequent Chapters

Chapter Two: Literature Review



The second chapter of the thesis will focus on the epidemiology of stroke and the various impact that a stroke causes to an individual diagnosed with a stroke. There will be a discussion on policies which influence return to work. Chapter two will also focus on the importance of Occupation on one's wellbeing. This section will also focus on the different approaches used to assist stroke survivors in the return to work process and the use of the Model of Self efficacy as a rehabilitation model will be discussed.

Chapter Three: Research Methodology

Chapter three describes the methodological principles of the study. The chapter will explain the study in terms of the; study design, study setting, the sampling strategy used when the participants were selected, data collection techniques and lastly the data analysis processes. In addition, the methods through which the trustworthiness and research ethics for the study were achieved are discussed in this chapter.

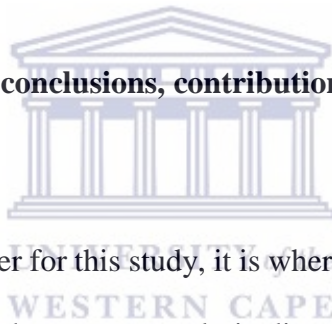
Chapter Four: Results

Chapter four concentrates on the findings of the study, it describes the patterns, trend and relationships which emerged from the analysis of the study. The findings of the study are presented as themes, categories and sub-categories.

Chapter Five: Discussion

This chapter discusses the findings of the study corresponding to the relevant literature. In chapter five the findings of the study will be interpreted and discussed in the frame work of the Model of Occupational Self Efficacy and PEO.

Chapter Six: Recommendations, conclusions, contribution of present study and implication for occupational therapists



Chapter six is the concluding chapter for this study, it is where the recommendations, conclusions and the significant contribution of the present study is discussed. This chapter also presents the implication of the findings of the study for Occupational Therapists.

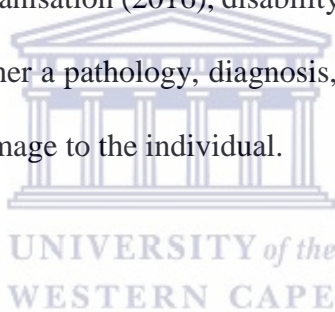
1.9 Definition of key terms

Stroke

A stroke is typically characterized as a neurological deficit attributed to an acute focal injury of the central nervous system (CNS) by a vascular cause, including cerebral infarction, intracerebral haemorrhage (ICH), and subarachnoid haemorrhage (SAH), and is a major cause of disability and death worldwide (Ralph & et al, 2003)

Disability

According to the World Health Organisation (2016), disability is used as an umbrella term and can be defined as an impairment of either a pathology, diagnosis, or any external influence such as a traumatic experience leading to damage to the individual.



Vocational Rehabilitation

Vocational rehabilitation is a strategy, which aims to enable person(s) with disability to secure or retain appropriate employment. This aids the stroke clients to reintegrate into society. Vocational rehabilitation not only supports returning to work but also in maintaining employment for stroke clients (Coole, Radford, & Grant , 2012).

Occupation

According to Varsson and Müllersdorf (2008), Occupation is a basic human need that provides meaning to life. Occupation is not normative; however, it depends on the subjective experience and it is possible using movement, functions and skills (Varsson & Müllersdorf , 2008).

Self-Efficacy

According to Schunk (2002), an individual's *self-efficacy* refers to their perceived capabilities for learning or performing behaviours at chosen levels. The author further explains that self-efficacy can influence an individual's choice in activities, their efforts, persistence and achievement (Schunk, 2002).

Supported employment

Supported employment can be characterized by Wehman (2012), as paid work in integrated work settings with ongoing support for individuals with disabilities in the open labour market. Paid work for individuals means the same payment for the same work as for workers without disabilities (Wehman, 2012).



Perceptions

According to Esa & Kannapiran (2014), perception is the process whereby people select, organize and interpret sensory stimulation into meaningful information about people and their work environment. (Esa & Kannapiran, 2014)

Experiences

Crepeau, Cohn & Schell (2009), define experiences as the knowledge or skill gained while involved in an event or subject over a period of time.

CHAPTER TWO: LITERATURE REVIEW AND THEORETICAL FRAMEWORK

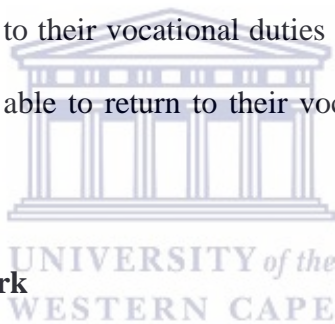
2.1 Introduction to the literature review

The literature review focuses on the importance of work and the benefits of it to persons who have suffered a stroke and as a result have a disability. Furthermore, the literature review highlights specific rehabilitation approaches and models which are used to aid individuals with stroke to return and prepare them for return to work. Thereafter the model (MOOSE) which is used to conceptualise this study is discussed. This chapter will discuss the 2.1 Epidemiology of Stroke in South Africa. In Section 2.2 the Policies affecting return to work are discussed. Work as an Occupation and its importance to wellbeing will be explained in section 2.3. Vocational Rehabilitation for clients diagnosed with stroke will be discussed in 2.4. In section 2.5 the Vocational training models will be explored, and in section 2.6 Supportive employment is discussed. Both the Social and Medical Model is explored in section 2.7. Lastly in section 2.8.1 the practised based model known as the Model of Occupational Self Efficacy (MOOSE) is discussed.

2.2 Epidemiology of Stroke in South Africa

In South Africa, stroke is responsible for an average of 25,000 deaths annually which is caused by various medical and contextual factors. There are 95,000 persons who suffered from stroke live with various forms of disability (Maredza, Bertram, & Tollman, 2015). According to Maredza, Bertram and Tollman (2015), there are few published studies which focus on the epidemiology of stroke in the rural parts of the country. The above authors state that there are many out of date evidence from these studies which indicates that as far back as the 1990's stroke was a major

contributing factor to the cause of death in South Africa (Maredza, Bertram, & Tollman, 2015). To assess the severity and to classify a stroke, medical doctors, nurses and therapists are able to administer the National Institutes of Health Stroke Scale. The national institute of health stroke scale is a 15-item neurologic assessment that provides a quantitative measure of the stroke related neurologic deficits (Hermelinda, 2016). The maximum score of the examination is 42 points. The higher the score, the more severe the effects of the stroke, the lower the score, the less severe the effects are of the stroke. A significant portion of the 95,000 citizens living with disability after stroke in rural areas, find it problematic to attend hospital appointments and rehabilitation services due to low socio-economic circumstances and contexts (Maredza, Bertram, & Tollman, 2015). As a result of this many do not return to their vocational duties and even more so do not know that there is a possibility that they are able to return to their vocational duties (Waddell & Burton, 2006).



2.3 Policies affecting return to work

2.3.1 White Paper on integration of PWD into the work place:

The National Development Plan (NDP) was approved in 2012. The plan envisions a country by 2030 which has eliminated poverty and has reduced inequality. The plan recognises that PWD are unable to develop to their full potential due to a vast range of barriers. Barriers which are highlighted in the plan are related to physical infrastructure, information technology and communication between stakeholders. Furthermore, the NDP is a strategy to reduce inequality and to promote the employment of persons with disability (The National Development Plan, 2012).

According to the White Paper on the integration of PWD, it is stipulated that PWD have economic rights. Economic rights include access to resources such as land, finance capital and decent work.

This is only possible if this right is reinforced. By enforcing this right, it will serve as a focal point for economic policies, plans and programmes (Integrated National Disability Strategy: White Paper, 1997:12). In order to do so, PWD must be actively able to participate in economic processes equally. The aim of economic justice is to create opportunities for all people to aid them to achieve economic and financial independence to reduce income inequalities.

2.3.2 Employment Equity Act 1998 (act 55 of 1998 as amended): Employment Equity regulations, 2014:

The purpose of the Employment Equity Act is to achieve equality in the work place, by setting policies in place which protects the employee and the employer. The act applies to all employers and workers and protects workers and job seekers from unfair discrimination and provides a framework for implementing affirmative action (Employment Equity Act, 2015). The Act stipulates that, “No person may be unfairly discriminated, directly or indirectly, against an employee in any employment policy or practice, on one or more grounds including race, gender, sex, pregnancy, marital status, origin, colour, sexual orientation, age and *disability*”. The Employment Equity Act (2015), protects individuals with disabilities, such as stroke, it allows for the individuals to continue being a contributing member so society and the working community. The act allows for persons who have a disability to pursue vocational opportunities. Marumoagae (2012), explains that employers should not be expected to employ people who cannot perform the vocational duties of a specified job. Marumoagae (2012), elaborates that it would not be fair to the employer to retain an “able bodied” or PWD, if they are unable to perform the tasks of a specified job, merely because the employee is disabled. (Marumoagae, 2012).

The Labour Relations Act No.66 of 1995, gives guidelines to ensure fair labour practices in the work place. *The code of good practice* aims to help employers and employees understand their

rights and obligations, promote certainty and reduce disputes to ensure that people with disabilities can enjoy and exercise their rights at work. If the employee suffers an injury or illness which affects their vocational duties such as a cerebral vascular accident, the employee's duty to keep in touch with the employer, if incapable to do so a family member should. For the employee to have a safe return to work, it may require vocational rehabilitation, transitional work programmes and where appropriate, temporary or permanent flexible working time. The Code of Good practice further specifies that that if achievable, the employers should offer the employee alternative work, reduced work or flexible work placement (Labour Relations Act, 1995). Although the Country has made progress in the policy which advocates for inclusion, there remains a gap in the return to work statistics of persons with stroke. According to the South African census 2011, there is a low open labour employment of persons with disability. The census found that the degree of difficulty is related to economic participation (Lehohla, 2011).

2.3.3 The Convention on the Rights of Persons with Disabilities (2006), Article 29

The United Nations Convention on the Rights of Persons with disability (2015), Article 29, states that persons with disabilities can and should effectively engage and participate in political and public life on an equal basis with others. Therefore, persons with a disability because of a stroke should be given the opportunity to engage in work activities and to do so freely as would any other person. The convention put forward the notion that society should change both their attitude and approach to persons with disability.

The Convention on the Rights of Persons with Disabilities takes into consideration that barriers experienced by persons with disability are not only perceptions and attitudes but also physical constraints. According to the United Nations Convention on Rights of Persons with Disability the

high levels of unemployment amongst people with various disabilities can be alluded to a variety of factors such as; as a result of inadequate education that result in low skill levels, discriminatory attitudes by employers and co-workers, inaccessible public transport, inaccessible and unsupportive work environments, inadequate and inaccessible provision for vocational rehabilitation and training, generally high levels of unemployment , inadequate access to information and last but not least ignorance in society (The United Nations, 2015).

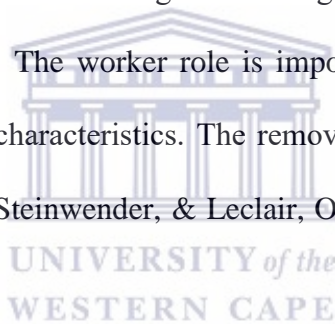
The Convention on the Rights of Persons with Disabilities acknowledges the struggles of persons with disabilities who live in rural areas. The above-mentioned factors affect vocational choices for PWD's significantly. One of the sectors mentioned in the convention on the Rights of persons with disability looks at individuals severely affected by exclusion due to disability living in rural areas. The Convention recognises that PWD living in rural areas often do not have any prospect of engaging in the formal business sector as a result of poverty, inaccessible public transport systems, lack of adequate schooling or accessible schooling and social rejection (The United Nations, 2015). Article 29 of the Convention on the Rights of Persons with Disabilities is important as PWD need to be involved in activities that promote the rights of PWD and that they should be involved in decisions made which affect them.

2.4 Work as an Occupation and Influence on Wellbeing:

Occupation' has been defined by McLaughlin-Gray (1997) as something that carries meaning for an individual. A more recent definition of 'occupation' was relayed by Christiansen, Baum, and Bass-Haugen (2005), as the engagement in activities and roles for the purpose of maintaining one's self in the environment and for relaxation purposes.

According to Hassan and Samwel (2009), stroke impacts day to day activities and disrupts the client's future plans. Once clients return home, it is then that the true impact of the stroke is felt as their plans the client once has, now shifts. Part of the real-life challenges faced stroke clients are that they struggle to deal with the loss of their future plans, not only the loss of their previous abilities. The loss of the stroke client's future plans often left the stroke client feeling distressed, the plan to travel, to be more active and spend time with children and grandchildren and the ability to return to work are now tainted by the stroke.

The importance of the worker role is often unnoticed in persons with disability and the importance there of. Law et al. (1996), describes wellbeing as the integration of an individual's emotional, spiritual and social characteristics. The worker role is important as it has an influence on the individual's emotional and social characteristics. The removal of occupation leads to increased stress and decreased health (Law, Steinwender, & Leclair, Occupational, Health and Wellbeing, 1998)



Waddell and Burton (2006) considered the importance of employment and re-employment for the sick and persons with disability such as stroke. It was found that re-employment lead to an improved self-esteem, improved general and mental health, and reduced psychological distress (Waddell & Burton, 2006). The benefits of employment according to Waddell & Burton (2006) are that it is therapeutic, it promotes recovery and rehabilitation and leads to better health outcomes. By returning to work or re-entering work it promotes full participation in society and independence, reduces poverty and improves quality of life and well-being (Waddell & Burton, 2006).

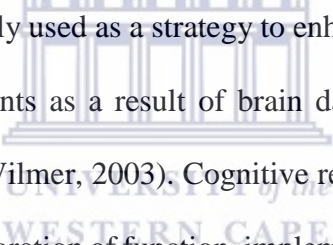
2.5 Vocational rehabilitation for clients diagnosed with stroke.

Rehabilitation measures target body functions and structures, activities and participation, environmental factors, and personal factors (Paul Kennedy, 2012). According to Paul Kennedy (2012), majority of the rehabilitation emphasis is placed on physical rehabilitation, cognitive rehabilitation and the client regaining their functionality, with little emphasis placed on reintegration into the work place. (Koehler, Wilhem, & Shoulson, 2011). Once the client has reached their physical peak of functionality they are discharged into the community. The problem which arises, is lack of re-employment or reintegration, this particular phenomenon occurs mostly in rural communities. Vocational rehabilitation is a strategy, which aims to enable person(s) with disability to secure or retain appropriate employment. This aids the stroke clients to reintegrate into society. Vocational rehabilitation services include vocational guidance, vocational training, placement and employment (Coetzee, Goliath, van der Westhuizen, & Van Niekerk, 2011). According to Buys (2015) Vocational guidance is referred to the planning phase in terms of returning the client to work, vocational training is seen as improving the client's ability to work, by improving the clients formal and informal work skills, such as work hardening, management of stress and work simplification methods (Buys, 2015). Work placement according to Coetzee et al. (2011) encompasses programmes to assist clients to prepare themselves to return to their previous work duties or their new alternative work. Work placement includes reasonable accommodation, it may also include skills training and retraining of skills.

2.5.1 Vocational Training models

Vocational rehabilitation is known to be a vital and supportive stepping stone which prepares the stroke survivor to enter or return to employment (Japp, 2005). Rehabilitation professionals such

as occupational therapists play a vital role and are placed in unique positions to facilitate the return to work process with injured or individuals with stroke. Recent evidence proposes that vocational rehabilitation interventions need to be targeted early and should be initiated before the client leaves the acute and discharge stroke units. Vocational rehabilitation maximizes the client's potential to have a positive return to work outcome. According to Corr and Wilmer (2003), return to work programmes should facilitate the development of skills, enable opportunities for retraining and promote links to employers. Cognitive Rehabilitation is central to brain injuries such as stroke and contributes significantly to the return to work success. According to Cicerone et al. (2002), 95% of rehabilitation facilities attending to persons with brain injury provide cognitive rehabilitation.



Cognitive rehabilitation is commonly used as a strategy to enhance functioning and independence in clients with cognitive impairments as a result of brain damage or disease, most commonly following TBI or stroke (Corr & Wilmer, 2003). Cognitive rehabilitation interventions involve a mixture of approaches aimed at restoration of function, implementation of compensatory strategies and environmental modification, and these can be integrated with approaches directed at dealing with the emotional responses to impairment (Mateer, 2005). Two of the most common strategies used in cognitive rehabilitation are the compensatory approach and remedial approach. The compensatory approach is based on the assumption that the client can regain independence by making use of compensation, when underlying deficits cannot be remediated. The compensatory approach is also known as the adaptive approach, as it ensures that the client's environment is suitably modified to substitute for loss of function (Mateer, 2005).

Compensatory strategies include teaching the client on keeping a calendar for appointments or a memory notebook to remind them of their list of duties at home or work. Further compensatory

techniques include advising a person with ataxia to position their arm to improve stability when picking up a glass or teaching energy conservation techniques. The critique of the compensatory approach found that clients may feel stigmatised as “handicapped” and that they require cognitive reasoning for the purpose of the compensatory techniques.

The remediation approach is defined by Mateer (2005) as intervention which engages the participant in learning activities that improve cognitive skills. Stroke affects executive functioning, which includes everyday occupations, such as carrying out a sequence of actions, planning a task, beginning a task, knowing when one has completed a task, or even becoming “lost” while in the middle of a task (Corr & Wilmer, 2003). Research has demonstrated that cognitive remediation interventions that incorporated elements of memory, processing speed, and attention led to significant improvements in a number of cognitive areas. The latter approach is critiqued by Blundon and Smits (2000), due to the minimal amount of transference of the learned skill to the functional setting. A study done by Hofgren, Esbjörnsson & Sunnerhagen (2010), indicated that cognitive rehabilitation plays a significant role in the return to work of clients who have suffered from brain injuries. The researchers collected data from 72 participants, 48 of the participants with the stroke diagnosis. The data gathered focused on the participants’ employment status after they had received cognitive rehabilitation. After a year, 13 out of the 48 stroke clients had returned to work. These authors found that clients who are most likely to return to work are those who attended rehabilitation sessions regularly and those who suffered mild strokes.

2.6 Supportive Employment

Supported employment can be characterized by Wehman (2012), as paid work in integrated work settings with ongoing support for individuals with disabilities in the open labour market. Paid work for individuals means the same payment for the same work as for workers without disabilities.

According to Wehman (2012), supported employment has made paid work possible for persons with disabilities who, in the past, were perceived as unable to work. It enables them to earn an income, develop their skills and learn to recognize their abilities. The programme has many phases, which the client moves through and the concentration on each phase depends on the clients' context. As a result of this, not all clients require each phase of the process (Wehman, 2012). According to Gobelet and Franchignoni (2006), by using the model of supported employment, studies showed that stroke patients are more successful in obtaining and maintaining a job than without the model. Vuadens et al. (2006) performed a study with stroke clients who participated in the supported employment programme. Among 130 patients followed over 3 years, 67% were competitively employed (Vuadens, 2006). According to the researchers for clients with moderate stroke, the supported employment model with job-site training and support is sometimes insufficient to maintain employment. This occurs when behavioural or the cognitive deficits are too significant. The critiques of this programme are that there remains a high possibility of job failure and in rural settings, it is not always financially possible to arrange transport.

The supported employment model has also proved to have an 80% success record in enabling clients with brain injury to return to work (Pape, 2014).

2.7 Social Model and Medical Model

In the *Medical model*, disability is defined as an illness or impairment. An individual's disability is as a result of their body or mind and is regarded as intrinsic to the individual (Murphy, O'Shea, Cooney & Casey, 2007). According to Sullivan (2011), the medical model is also commonly known as the "individual" model. The objective of the medical model is often to cure or rehabilitate the individual in order to "fix" the "defect", through surgery of prosthetic limbs. This is done in order for the individual to become closer to what is seen as "normal" in society. For example, if

an individual who has suffered a cerebral vascular accident has a speech impairment, the main object is to fix the impairment, in order for the “disabled” individual to be seen as normal. If this is not achieved the individual is seen as “abnormal” (American Stroke Association, 2015). Conversely, according to Zedda (2016), individuals should not be that swift to push aside the Medical model, as curative treatment is still needed and aids the person(s) with disability to participate in society. The model which opposes the *Medical Model* is known as the *Social Model*. The Social Model encompasses a more humanistic approach toward individuals with an impairment as a result of an injury or illness. The social model aims to eradicate the notion that persons with disability are seen as inferior, the model aims to include persons with disability instead of excluding. According to Oliver (1996), in the social model, disability is therefore everything found in society that isolates and excludes disabled people: prejudice and discrimination, inaccessible buildings and transportation systems, segregated education, and vocational opportunities which are viewed as too complex for persons with disability or once the individual has suffered a stroke, no longer being capable to return to work. According to the Michigan Disability Rights Coalition by Wyeth (2012), the Social Model of Disability faces two challenges. As population’s increases in numbers, people with disability will increase, making it more difficult for society to adjust. Secondly, the social model’s notions can be difficult to understand by dedicated professionals in fields of charities and rehabilitation. Many professionals need to be persuaded, that their roles need to change from “cure or care” to less obtrusive one to helping persons with disability take control of their own lives (Wyeth, 2012).

2.8 Theoretical Frame work

2.8.1 Model of Occupational Self Efficacy

The Model of Occupational Self Efficacy (MOOSE) was established by Soeker (2012). The model is a dynamic framework, to help brain injured clients to return to work. The model gives the therapist guidelines to operationalise the model. There are four stages that assist the brain injured individual to resume their worker role:

Stage One: A strong belief in functional ability, this stage focuses on the process of introspection and self-reflection of the individual's life circumstances (Soeker, 2012). During this stage the therapist will gain insight into the stroke participant's context, in order to get a holistic understanding of the individual. *Stage Two: Use of self*, in this stage the individual progresses toward a realisation that, the individual can take control of their life circumstances and can initiate tasks autonomously (Soeker, 2012). As a result of the model encompassing the principle of client centeredness, the individual input is seen as vital to improve the client's self-reliance by valuing the client's input.

Stage Three: Creation of competency through occupational engagement: Soeker (2012), defines this stage as the stage of Creation of competency. The individual's competency is developed through and by occupational engagement. In this stage the client, independently or with the therapist's help increases their knowledge base (Soeker, 2012). The individual is able to improve their knowledge with regards to their medical problems, i.e. stroke and how to prevent it. The individual can make adaptations with regards to coping with stress and work and home. This phase is described by the utilisation of resources and social capital available for the purpose of task participation (Soeker, 2012). *Stage four: Capable individual*: Once the individual has together with the therapist been taken through the stages, at the fourth stage it is hoped that a capable

individual will emerge. According to Soeker (2012), in this stage, once the individual has engaged in the process and engaged in occupational roles, the individual will be capable to reassume their worker role.

In conclusion this study is linked to the lack of research regarding the perceptions and experiences of individuals with disability about returning to work specifically focusing on individuals in a rural community setting. Previously the MOOSE program was implemented with TBI women in the Western Cape and many of these participants could return to work (Soeker & Darries, 2016). Furthermore, in a pre-post intervention study conducted with individuals with mild to moderate brain injury, the participants that participated in the MOOSE had a significant improvement with cognition and 80% of them returned to work (Soeker, 2017). The literature which was found is centralised around the individuals in the more established communities, where there are rehabilitation centres and resources that are much more easily accessible, as well as facilities which offer enabling of skills training and retraining. In a rural setting it is more difficult to have an individual with a disability return to work, because of the stigma attached to disability and the misconception that a person with disability will slow down production. This affects the person(s) with disability's self-esteem and the way in which they view their ability to perform their work roles and skills. By making use of MOOSE the therapist will enable the participants on adapting their working environments in conjunction with their employers to maintain the participant's contribution to the production. By educating the participants on adapting their environments, will give them a sense of accomplishment by the participants being able to participate in their vocational duties. According to Barnes (1985), many individuals with disabilities, will settle for a job that under uses their skills due to a lack of self-esteem rather than continue to return to their previous positions in the work place, even though they are able to perform the necessary duties.

The MOOSE program aims to improve the views of the participants as they succeed in work related occupations. The goal of the MOOSE model is achieved once the participants actively engages in healthy and meaningful occupations to the extent that their self – efficacy improves. The aim of the model is to produce a more goal orientated and motivated individual who is capable of maintaining their worker role independently. Therefore, the current study described the experiences and perceptions of individuals diagnosed with a stroke about the usefulness of the MOOSE in assisting them in returning to their worker role particularly in a rural community setting.

2.9 Summary

Based on the above literature, the evidence suggests that CVA survivors are subjected to negative attitudes in the work place and in society. The attitudes of employers and general community members are negatively affected by the lack of knowledge regarding stroke, especially during the return to work process whereby employers are hesitant to have the CVA survivors return to work. The literature review suggests that although there are models and approaches to assist the persons with disabilities to return to work, these approaches are not without critique. Although there has been research done on the return to work process of individuals with various types of disabilities, not much emphasis has been placed on the return to work of individuals with CVA in a rural community. The current study explored the experiences of CVA survivors of returning to work after they have participated in a vocational rehabilitation programme using the framework of MOOSE.

CHAPTER THREE: RESEARCH METHODOLOGY

3.1 Introduction

Chapter three will discuss the research methodology utilised in the study. In section 3.2 the research paradigm of the study is discussed. Section 3.3 focuses on the sampling strategy which was used for the selection of the study participants. Section 3.4 explores the process that was followed for ethical approval of the study. In section 3.5 a description of participants for the study is provided. In section 3.6 and 3.7 the data collection technique and data analysis are discussed. Lastly, the section 3.8 and 3.9 research trustworthiness and the ethical statement of the study are discussed.

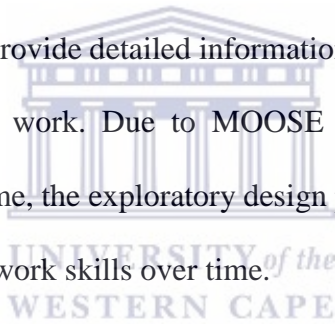
3.2 Research design

3.2.1 Descriptive Research Design

In the current study descriptive research was used to explore and describe the perceptions and experiences of individuals with CVA about returning to work in a rural community and the challenges they face. Burns and Grove (2003) define descriptive research as being designed to "provide a picture of a situation as it naturally happens". Burns and Grove (2003) further explain that descriptive research may be used to develop theories, make judgements and also to justify current practice. According to Lambert and Lambert (2012), the goal of descriptive studies is a comprehensive summarization, in everyday terms, of specific events experienced by individuals or groups of individuals. The descriptive research design was chosen within this study as it allowed the researcher to make judgements, by utilizing the perspectives of the research participants', with regards to usefulness of MOOSE in enabling them to return to work in a rural community.

3.2.2 Exploratory Research Design

In conjunction with the descriptive research design the researcher made use of the exploratory design. As stated by Cuthill (2002), the exploratory design is conducted about a research problem when there are few or no earlier studies to refer to or rely upon to predict an outcome. The focus of exploratory designs is often to establish an understanding of how best to proceed in studying an issue or what methodology would effectively apply to gathering information about the issue, in the proposed study, there is an exploration of how MOOSE influences the CVA patients return to work process. Cuthill (2002), mentions that the goals of the exploratory research are intended to provide various insights into the research topic (Cuthill, 2002). By making use of the exploratory design, the researcher was able to provide detailed information on the contexts of participants and their concerns about returning to work. Due to MOOSE being a model that facilitates the development of work skills over time, the exploratory design provided a well-grounded picture of how the participants develop their work skills over time.



3.3 Description of Study setting

The area of Calvinia was founded in 1845 on the farm Hoogekraal which was purchased by the Dutch Reformed Church. Originally the name of the village and region was called Hantam. The name Hantam has its origins with the Khoi people and it is believed that the name refers to “the hill where the red nut sedge grows”. Today the Municipality wherein Calvinia lies is called Hantam. Calvinia has transformed in to a well-preserved town with architectural heritage which provides residents and visitors with an interesting window into its past. Calvinia is mainly made up of farm owners and farm workers and its economy continues to revolve around wool and mutton farming. According to Statistics South Africa (2011), the population of Calvinia consists of nine thousand-six hundred and eighty people. Abraham Esau Hospital is a secondary hospital which

is based in Calvinia. The hospital services the entire Hantam municipality which consists of Loriesfontein, Sutherland, Fraserberg, Williston, Niewoudtville and Brandvlei. The hospitals focus is to provide a service which is accessible to everyone in the community.

3.4. Sampling

The sampling technique that was used to select participants was purposeful sampling. Fourteen individuals diagnosed with a CVA were purposively selected to ensure the researcher explored various perceptions and experiences of how MOOSE influenced the participants` ability to return to work. According to Brink and Van Rensburg (2012) the advantage of using the purposive sampling in a small community, is that it is more convenient and economical than other sampling methods. Patton (2002) indicates that the advantage of purposive sampling lies in selecting information rich cases. Saturation was determined by the number of interview sessions per participant in the current study. In the context of the current study the researcher obtained saturation of information after the second interview with the each participant. Saturation was achieved when the same information or recurring themes were presented by the participants.

The inclusion criteria for the study were as follows:

- Participants who were diagnosed with either a mild to moderate cerebral vascular accident.
- Participants should have been living with the stroke condition for at least one year post diagnosis.
- Participants who were employed for at least six months after the completion of the vocational rehabilitation programme, using MOOSE.
- Participants who were employed before the injury for a period of 3 months before the CVA.

The participants who were able to communicate efficiently, in either English and Afrikaans.

- Participants who lived in the Calvinia District and were 18- 55 years old.

The Exclusion Criteria were:

- Participants who had multiple disabilities and severe cerebral vascular accidents.
- Finally, Participants who did not have active symptoms related to a psychiatric condition according to the DSM-V (Diagnostic and Statistical Manual of Mental Disorders).

3.5 Procedure

The current study has received ethical clearance from the Biomedical Research Ethics Committee (BMREC) of the University of the Western Cape. Ethical approval was granted by the CEO of the Abraham Esau Hospital and Calvinia Primary Health Centre to evaluate their statistical record to source potential research participants.

3.5.1 Participant Recruitment Procedure

The researcher made use of the medical records and personal contact information of the participants that was provided by the multidisciplinary team, the participants were then contacted telephonically. Participants who did not have access to telephones, the researcher used their addresses to contact the participants at their homes. The researcher utilised screening interviews to assess if the participants fit the inclusion criteria of the study, a group of seven males and one female were selected to participate in the study. In addition, one key informant who was a qualified occupational therapist participated in the study. Two of the eight participants were receiving on going speech therapy. Of the eight participants two were unemployed during their rehabilitation. As a result of their unemployment status during the MOOSE programme incentives needed to be provided. In these cases, incentives by means of sandwiches were provided as well as tea. According to Groth (2010), incentives are coercive, especially for people who have limited

financial resources. Soeker (2004), further elaborates and reports that incentives in the form of snack, transport money and babysitters are of great value for ensuring participation and should be viewed as a form of gratitude for the participants time to participate in the study rather than coercion.

3.6 Description of study activities and Participants

Eight participants were sampled between the ages of 18 and 55 years. In terms of race all the participants are coloured. NB: All the eight participants in the current study completed the eight week intervention sessions, each participant participated in two, one hour sessions per week.

Table 1

Week	Stages of the Model: Aim of phase	Activities – One hour sessions that was had with the participants
Week one -two	Stage 1: Strong belief in one’s self	<ul style="list-style-type: none"> - Building IPR (Interpersonal Relationship) with the client, to gain insight into the client’s holistic context. - To explore with the participant what activities the participant engaged in before the stroke and how the stroke has affected those occupations, physically, emotionally and mentally - Self-concept activity: In these sessions the participants would have to identify who they are using roles, such as father or mother, then discuss it in the sessions. Estimate of self-concept: Looking at yourself critically: Writing down words which describe who you are

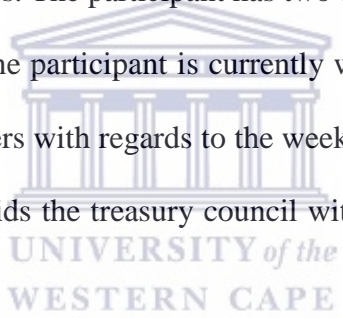
Week three-four	Stage 2: Use of self	<p>During stage two, the sessions were used to explore and probe to find out which occupations are important to the participants and on which activities the participants would want to focus on in sessions.</p> <ul style="list-style-type: none"> - Interest check list <p>Interpersonal skills: The participants introduced themselves to three strangers in the community and to start a conversation. This assisted in determining the level of the participants self-esteem and to practice the regain of interpersonal skills. The participants also needed to interact with people and ask sincere questions demonstrating concern, communicating both verbally and non-verbally in ways that demonstrate courtesy and love. Participants needed to be able to listen effectively, handle difficult conversations, discipline his anger, and help resolve conflict. Exploring relative distance and position: The safe distance between pairs of people is very culture dependent as is the degree of eye contact which is permitted and certainly the amount of touch. What is explored here is the simultaneous meeting of eyes and the aware adjustment of distance between partners who face each other. Participants were asked to find a comfortable distance and explore their feelings and thoughts at that position, as they moved from a distance towards the comfort zone and as they went closer. This will aid the OT to assess if the client has spatial relations discrepancies.</p>
Week five to six	Stage 3: Creation of competency through occupational engagement	<ul style="list-style-type: none"> - Time management: Time pies: This Assessed time spent on activities and how to make use of his time more effectively - Improving concentration: Educated the participant to make use of incentives Prioritise tasks and how to apply structure, here the time management activities skills need to be applied. - Learning new information: Executive function Due to the participants need to learn new information, they were encouraged to take the main idea-summarising an article - Memory How to remember a route: Make use of a map on the routes the client travels to. Then the participants put in landmarks

		<p>and highlighted with different colours. If one creates the map you will remember it better.</p> <p>The participants then wrote step by step instructions for getting to one place and then to another.</p> <p>Concentration</p> <p>The participant and therapist together came up with ways to make use of incentives</p> <ul style="list-style-type: none"> - Prioritise tasks and how to apply structure, here the time management activities skills need to be utilised - Embedded Words: Task to improve divided attention. The aim is to find particular words based on instructions. <p><u>Executive Skills</u></p> <ul style="list-style-type: none"> -Five activities task. Involves multi-tasking and planning. -Goal setting, planning and monitoring. Self-regulation is necessary in any goal directed activity. Identifying goals, planning, monitoring progress, and adjusting behaviour are important skills to practice. - Break a project down into manageable pieces. The participants needed to identify reasonable plans (with timelines) for completing each piece. They needed to be sure that all steps have been explicitly identified. - Self-monitor while working. While working the participants were asked to set a time. By doing so it assisted as a reminder to check on whether one is paying attention and understanding. When they did not understand they needed to ask themselves, what might be the problem? Are there words they did not know? Do they know what the directions are? Is there someone they could ask for help?
<p>Week seven to eight</p>	<p>Stage 4: Capable individual</p>	<p>Emotional adjustment</p> <ul style="list-style-type: none"> -Dealing with fatigue: -Assisted the participant to recognise early warning signs and Saying no to excessive demand, etc. -Awareness Skills quiz <p>Work site visit: The OT educated on work simplification and energy conservation techniques.</p> <p>Based on the participants progress and regress, duties were adapted.</p>

		Ergonomics was discussed with the participant and employer.
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Participant 1 (P1):

G.W is 54-year-old male, who resides in the area of Calvinia. Suffered a stroke in December 2015. The participant is coloured, and his main language is Afrikaans. The participant is a pastor by profession and has been for 30 years. The participant has two children and is married. His highest educational level is grade eight. The participant is currently working at the church and oversees setting up schedules for the ministers with regards to the weekly services and family visits which need to be done. The participant aids the treasury council with the management of the financial budget of the church.



Participant 2 (P2):

P.K is a 55-year-old male who resides in the Calvinia area. The participant is married and has one daughter. His primary language is Afrikaans and is coloured, he is also able to write and speak in English. The participant is a long-distance taxi driver. The participant’s highest grade passed is grade three. The participant has returned to his job but with various accommodations done in the work environment. The participant drives less in the week, it went from four times a week to two times that he needs to do driving. Previously the participant drove up to 100km to towns but is now allowed to do short distances such as 50km-70km.

Participant 3 (P3):

J.F is a 59-year-old male, from Calvinia, the participant is widowed and has two sons. The participant is Afrikaans speaking and is able to write and speak English. J. F's racial classification is coloured. The participant is an entrepreneur and has his own car mechanical business. The client highest grade passed is grade twelve. The participant currently focuses on the administration tasks of the business where previously he used to do both mechanical tasks and administration tasks.

Participant 4 (P4):

J.L is a 46-year-old male and works as a road works supervisor. The client suffered a stroke in January 2015. He is married with three dependants. The participant is Afrikaans speaking and is coloured. The client is from Calvinia and his highest grade passed is grade ten. The participant has returned to his previous managerial duties at the road works site at the same company.

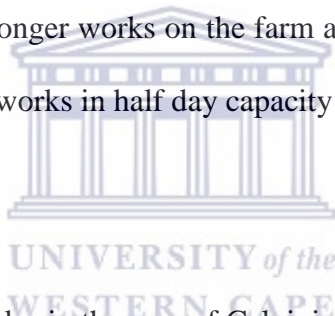
Participant 5 (P5)

Participant five is a 43-year-old male who resides in the Calvinia area. The participant's primary language is Afrikaans. The participant is married and does not have any dependants. The participant suffered a stroke in the year 2015 and was referred to Occupational Therapy via a Medical Doctor and is a right hemiplegic. As a result of the stroke the participant suffered from verbal apraxia. The participant was referred to Occupational Therapy due to a growing concern that he might not be able to return to work once he has completed rehabilitation. Participant five has had poor hand function in his right hand and difficulty with fine motor movement. The

participant works in the preparation room at the Ramskop Abattoir. His duties consist of cutting the skin of the sheep once they have been slaughtered.

Participant 6 (P6)

B.T is a thirty-eight-year-old female and work on a farm 60km from Calvinia. She has five children and is divorced. The participant suffered a stroke in April 2016. She is a general worker on the farm and her main duties are; cleaning the main farm house, doing laundry and preparing supper for the family. The participant no longer works on the farm and is employed as a general worker in a local restaurant. She currently works in half day capacity (7h00 am – 14h00 pm).



Participant 7 (P7)

T.B is a 44-year-old male who resides in the area of Calvinia. The participant works as an admin clerk at the post office. The participant has been working at the local post office for 26 years. He suffered a stroke in May 2016, he suffered speech impairments as well as cognitive deficits namely; short term memory deficits and concentration. The participant is currently working at the post office clerk. The participants duties include, receiving letters and parcels and then placing them into mail bags, sorting incoming and outgoing mail and providing assistance to the public regarding mail enquiries. The participant is married and has three children.

Key Informant 1:

The key informant is a female Occupational Therapist who is currently living in the community of Calvinia. The key informant speaks both English and Afrikaans and was involved in the vocational rehabilitation of the participants in the study.

3.7. Data Collection

3.7.1 Data Collection Technique

In the current study, data collection consisted of semi-structured interviews and focus groups. The latter data collection methods have been deemed as the most appropriate for this study as it provided an in depth understanding of the perceptions and experiences that the research participants experienced about the MOOSE in relation to returning to work.

Semi structured interviews

Semi structured interviews are discussions, usually one-on-one between an interviewer and an individual, for the purpose of gathering information on a specific set of topics (Harrell & Bradley, 2009). According to Jamshed (2014), semi-structured interviews are where participants answer open-ended questions, this form of interview according to the author is widely used by different healthcare professionals in their research. Semi-structured interviews are based on a guide of questions which are set up before the interview takes place (Jamshed, 2014).

Interviews were conducted at the participant's homes as they felt it was more comfortable and they could speak freely. The researcher conducted semi-structured interviews (40- 60 minutes in duration) with the seven participants, the interviews took place until saturation was achieved (see Appendix E for the semi structured interview guide). Once the participants completed the MOOSE program and returned to work, the researcher conducted the interviews to investigate how the MOOSE has influenced the participants return to work. Participants were hesitant to have

interviews done at work and preferred that it was done after work, so they could speak openly about their experiences.

Key informant

According to Given (2008), key informants assist in establishing a link between the researcher and the community wherein the research is being conducted. Information received from key informants is often conducted through interviews and informal conversations. Two semi structured interviews were conducted with the one key informant to gain more information about the participants performance during the sessions. The key informant was useful as she could give more background into the community, as she was able to observe social patterns in the community and was able to give more insight into what the participant experience in the communities. Given (2008) further indicates that a key informants views are taken in combination with the interviews which were conducted with the participants and the researcher's observations and findings. The interviews with the key informants were conducted at the hospital as it was more convenient for the key informant to meet at their place of employment.

Focus Groups

Focus Groups were used to obtain a variety of opinions on a particular topic used for testing or developing semi structured interview guides (Harrell & Bradley, 2009). According to Patton (2002), focus group interviews are interviews which are carefully designed for participants to express their point of view in a group setting. A focus group nurtures different perceptions and provides an opportunity for participants to express their experiences and allows the researcher to gather information missed (Patton, 2002). Two focus groups (40- 60 minutes in duration) were held with participants in order to obtain a detailed description of the experiences and perceptions

of individuals living with stroke about the usefulness of the MOOSE in assisting them in returning to work (see Appendix E for questions). By making use of focus groups the researcher was able to explain the findings that appeared conflicting or contradictory from the interviews. The researcher used the focus groups to ask the participants to discuss their opinions regarding their experience of returning to work. Focus groups were held at the community library hall Tuesday afternoons. The motivation for conducting the focus groups in the community hall was due to the fact that it was closer to the participant's homes as opposed to the hospital and that it was a quiet environment that was conducive to focus group discussion.

3.7.2 Data Analysis

According to Hatch (2002), data analysis is an organized search for meaning. Hatch (2002), reports further that through data analysis the researcher is able to process qualitative data in order to develop conclusions and communicate it to others. (Hatch, 2002). A number of data analysis techniques were applied to the data collected in this study. These techniques are described in the following sections.

3.7.3 Deductive and Inductive reasoning

In this study both deductive and inductive methods of reasoning was utilised. By applying the deductive approach, the researcher applied the deductive reasoning after analysing the findings of the study that could link to the findings of the study to the study objectives. Inductive reasoning is commonly used in qualitative data analysis that is employed in the social, behavioural and health sciences (Macqueen, Namey & Guest 2012). This researcher applied the inductive approach parallel to the deductive method to explore the possibility of new emerging themes collected from

the data and observations. By utilising inductive reasoning, the researcher identified possible theories that could aid in the development and implementation of new rehabilitation strategies for returning stroke survivors to work in a rural community.

3.7.4 Thematic analysis

The data obtained from the semi structured interviews and focus groups were transcribed verbatim by the researcher. Transcription refers to the word-by-word reproduction of verbal data, where the written words are an exact replication of the audio recorded words (Poland, 1995). In the current study thematic data analysis was utilised, the techniques advocated by using Braun and Clarke's (2006) was used in the current study. Braun and Clark described their thematic analysis technique in six phases. The researcher utilised the six-step data analysis process as described by Braun and Clarke (2006). The six steps are as follows: 1) Becoming familiar with the data through transcription. 2) Generating initial codes 3) Searching for themes. 4) Reviewing themes. 5) Defining and naming themes and 6) Producing the report.

The above steps were followed to assist the researcher to gain a better understanding of the information which was recorded. The transcripts which was taken down verbatim, was read thoroughly and re-read multiple times. With this the researcher made notes linked to the participant's quotes that related to relevant literature. Once the interviews were transcribed the researcher proceeded to coding. The coding was conducted by analysing and underlining the meanings of text in each transcript which was transcribed. The cut and paste method was used, this was done to compare codes in the transcripts and to look for resemblances in meanings and similarities. Thereafter the coded data was further analysed and classified into categories. The categories contained common meanings which was pertinent to the codes. One the categories became clearer,

patterns of relationship arose from the categories to frame themes, which is discussed in the current study. According to Braun and Clarke (2006) thematic analysis is a qualitative analytic method for identifying, analysing and reporting patterns (themes) within data. Thematic data analysis was used as a means of analysing the data that was collected through the semi-structured interviews and focus groups with individuals diagnosed with a CVA.

3.7.5 Reflexivity

The researcher had to reflect on preconceived ideas and possible biases which could influence the study findings. To prevent this, the researcher made use of a reflective journal to record feelings, observations and ideas which might play a role in influencing the objectivity of the study. The researcher made use of a journal, she was able to enhance the ability to maintain a reflexive demeanour which included the reasons for the research topic, and assumptions regarding participants sexual orientation, gender, race/ethnicity or socio-economic status (Tufford & Newman, 2010). In doing so it allowed the researcher to confront assumptions and encourage objective interact between the researcher and the research data.

3.8 Establishing trustworthiness

To ensure that the study was credible, the researcher made use of the four strategies developed by Krefting (1991), these strategies are; (a) truth value, (b) applicability, (c) consistency and (d) neutrality. These are methods which ensures a study's credibility.

3.8.1 Truth value

Truth value, according to Krefting (1991), is described as being concerned with the confidence that the researcher has in the truth of the findings based on the research design, the informants and the context. Krefting (1991) explains further that truth value is subject orientated and this is termed as credibility. The term *credibility* suggests that the qualitative study is credible when it presents such accurate and true descriptions or interpretation of human experience, that those who share these experiences would immediately recognise the descriptions. To ensure the truthfulness of the data, the researcher audio-taped the interviews which were held with the participants. The audiotape was then transcribed verbatim. By doing this it allowed the researcher to portray an accurate representation of the experiences and perceptions of the participant.

3.8.2 Peer review

Peer review entails having an external qualified researcher examine the research processes and data interpretations. The peer reviewer verifies that the data were collected and analysed in an appropriate and systematic manner and, in many instances, that reasonable conclusions were drawn (Pitney, 2004). The peer review in the study was completed by the researcher's supervisor (s) and occupational therapist that are experts in the area of qualitative research.

3.8.3 Applicability

Applicability can be defined as the degree to which the findings can be applied to different contexts and settings or with other groups (Krefting, 1991). Applicability was achieved through member checking and peer review. *Member checking* was achieved particularly when the findings of the research i.e. themes were presented to all the participants, they could then comment on the

accuracy of the information. If changes were suggested, then the researcher re-analysed the findings.

3.8.4 Consistency

According to Krefting (1991) consistency of a study can be defined by the criterion of dependability. Dependability of findings of the study was conducted with the same participants or within a similar context. Through the strategy of coding and re-coding, the researcher recoded the data found into summarised codes. The researcher achieved this by giving a detailed description of the research method and peer examination. To further ensure the consistency of this study, the study proposal was approved by the higher degree and Research Ethics committee of the University of the Western Cape.



3.8.5 Neutrality

Neutrality is the exclusion of the researchers own bias and prejudices affecting the research (Krefting, 1991). To ensure neutrality the researcher kept a reflective journal to document experiences and field notes. This ensured that the researcher could reflect on their own bias if it should arise. Neutrality was also ensured by the use of an audit trail.

Trustworthiness of a study may be established if a reader is able to audit the events and actions of the researcher. Akkerman et al. (2006) suggests that audit trails are a means of assuring quality in qualitative studies.

3.9 Ethics Statement

The research study commenced after obtaining approval from the Research Ethics Committee from the University of the Western Cape and the Chief Executive Officer at Abraham Esau Hospital. Autonomy means self-governing and comes from a Greek word meaning independent (Collier, 2006). Fisher (2013) further explains that autonomy is achieved when the researcher respects the participants' right to self-determine a course of action and independent decision making. The precautions taken to ensure autonomy, were that the researcher ensured that the participation in the research study was voluntary and that no bribery took place. The participants' decision to participate in the research was made from an informed position; the participants were talked through the process and explained what was expected of their participation and what the study was about. The participants were briefed in their preferred language and they were given information sheets in Afrikaans. The research participants provided informed consent before they participated in the research study. Before the research could commence, the researcher obtained permission from the Hospital's Manager to conduct the research in the Hospital and Community Health Care Centre setting. Beneficence refers to having compassion for the participant's; taking positive action to help others; desire to do good; core principle of our participants advocacy (Fisher, 2013). The purpose of the study was thoroughly explained to each participant prior to the conduction of the study. Non-maleficence refers to avoidance of harm or hurt (Fisher, 2013). According to Stevens (2013) researchers should endeavour to ensure that research participants are protected from undue intrusion, distress, indignity, physical discomfort, personal embarrassment, or psychological or other harm. Interviews were conducted in a place where the participant felt comfortable and where they felt safe. The data collected during the study was kept safe and stored in a password protected computer (the data will be stored for five years). Once an interview was

completed the researcher placed the interviews in a safe in the researcher's office. Confidentiality was further maintained by using pseudonyms in all written work that culminated from the study. Confidentiality was also ensured by means of which all audio recordings were transcribed only by the researcher, who stored all audio information in a password protected computer. *Anonymity*, according to the Concise Oxford Dictionary (2016), anonymity is defined as the unknown name or unknown authorship, while confidentiality is defined as spoken or written confidence. Anonymity was ensured by using pseudonyms instead of the participants real names and this was ensured in all the documentation related to the research project. The subject of anonymity was discussed with the participants prior to their participation in the research.

3.10. Summary

In conclusion, the research methodology which was presented was employed to explore the experiences and perceptions of individuals with stroke about returning to work in a rural community setting, using the Model of Occupational Self Efficacy. An exploratory descriptive research design was utilised to describe the experiences of the participants. In the following chapter the findings of this study will be discussed and presented which will include the themes and categories that emanated from the data which was obtained from the research participants.

CHAPTER FOUR: RESEARCH FINDINGS

4.1 Introduction

The results of the study are discussed in themes, categories and sub-categories which relate to the participants experiences and their perception of the stroke (CVA) survivor's resumption of their worker role in a rural community. The findings are presented according to four main themes developed from the categories. Theme one is related to the barriers that might hinder the participant's resumption of work following the stroke (CVA). Theme two presents the facilitators which enabled the participants to return to work. Theme three presents the strategies utilised by the participants in adapting to their work roles. Theme four presents how the stroke survivors experienced the programme after they participated in it. The four main themes are presented below.

Theme One: Obstacles which affects the return to work of CVA Participants in a rural community.

Theme Two: Establishing a strong belief in functional ability through occupation.

Theme Three: Adaptation strategies that enhances the work participation of stroke survivors in a rural community.

Theme Four: The MOOSE enables transition to the worker role in a rural context.

4.2 Theme 1: Obstacles which affects the return to work of individuals with CVA in a rural community

Theme one represents the participants experiences of the effects of stroke on their former selves. The theme depicts the shift in the participant’s capabilities as a result of their new realities due to psychosocial, emotional, physical and cognitive changes. Theme one highlights the lack of knowledge amongst participants regarding to return to work and the services offered in a rural community.

Theme one: Barrier	Categories
Obstacles which affect the return to work of individuals with CVA in a rural community.	<ul style="list-style-type: none"> • Loss of functional abilities affected the return to work of individuals with CVA • The perception of a CVA in a rural community and the stigma related to CVA



One participants quote emphasises the person he was before the stroke and the person after the stroke. He said:

Maar ek weet miskien is daar 'n kans dat ek nie meer kan preek nie. (P3; JF)

“But, I know maybe there is a chance that I will not be able to preach”. (P3; JF)

4.2.1 Loss of functional abilities affected the return to work of individuals with CVA

This category focuses in the participant's loss of their functional capabilities. It describes how the stroke affects their capacity to perform a wide range of occupational roles and tasks due to the stroke. In the first stage of MOOSE, which is the introspection phase there is a lack of understanding as to how the stroke affects their mental, physical and emotional functioning. One participant reflects on the first stage of the process, and stated:

Dit was baie sleg want ek will terug werk toe gaan, en beter raak maar niemand wil my help nie. Niemand kon vir my se met wie ek moet praat nie (P6:SL)

That was very bad, because I wanted to go back to work, and I wanted to get better, but no one wanted to help me. No one could tell me who I needed to speak to (P6:SL)

The above statement indicates that as a result of insufficient information regarding diagnosis and rehabilitation participants feel helpless. The participants find themselves in a phase of Occupational Dysfunction. The participants found it difficult to make adaptations if they did not receive or have the resources and insight into their disability and how it affects their function.

- **Loss of self-esteem**

During the first stage of MOOSE, participants express their lack of self-esteem after the stroke. After the stroke the participants no longer viewed themselves as capable individuals. When disclosing their hopes for the future many of them expressed the need to return to work but doubted in their capabilities. It was evident that the stroke had brought about fear and uncertainty of the future and vulnerability came to the surface when facilitating and developing future work goals in the sessions. A statement by a participant reflects the lack of self-esteem he has:

“Dit is meer hoe kan ek se uhm soes ek glo nou in myself. Voor die program het ek net gevoel ek sal nooit weer enige iets kan doen nie. Ek was bang om terug werk toe te gaan want ek het gedink wat gaan die mense van my se, maar ek worry nie, so lank ek net werk verstaan “(P5:SL).

“It is more, how can I say. uhm like I believe in myself now. Before the program I felt like I would never be able to do anything again. I was scared to go back to work, because I thought what are the people going to say about me? I don’t care, as long as my work understands” P5:SL).

Another participant felt that the stroke influenced how he seen as a man and this made him feel old. He wanted to engage in work roles. By “being able to do” the participants are able to master activities which has become obscure after the stroke and participants no longer feel they are capable.

“Ek het rerig gedink ek sal nooit weer kan werk nie en dat alles soe net verkeerd gaan in my lewe na die beroerte en mense my soe sal judge nie. Ek voel ek is nog jonk en ek wil nie oud voor my tyd raak nie” (P5:SL)

“I really thought that I would never be able to work again and that everything just went wrong after the stroke and that people would judge me the way they did. I feel I am still young and I do not want to age before my time” (P5:SL)

The impact of the stroke on their self-esteem made it difficult for the participants to set therapeutic goals in the sessions.

“Dit het gevoel ek raak nie beter nie en daar is niks wat ek daaroor kan doen nie” (P1:GW).

“It felt like I was not getting better and there was nothing I could do about it”. (P1:GW).

Participants felt hopeless regarding their circumstance and were not aware that there was a possibility of regaining function after the stroke. The above statement emphasises the participants concern and feeling of hopelessness about his diagnosis. It displays that he was distressed and frustrated that his recovery period was taking longer than he had expected. The participant wanted to return to work as soon as he could to be able to provide financially for his family. The participant further expresses his concern about working and being the man in the house.

uhm when am I going back to work or when am I starting again and that was a very big problem because we didn't know if I was going to get paid when I was off sick (P3; JF)

- **A lack of awareness of what processes to follow when returning to work**

Through participation in the stages of the MOOSE, the participants explained their experiences after the initial stage of the stroke. They often found themselves overcome with anxiety and distress of not knowing what was happening to them. They expressed that they did not fully understand their prognosis and doubted that they would recover. One participant stated:

“Toe ek wakker skrik toe kan my arm nie beweeg nie. Ek was bang, ek's mos n man, ek moet na my kinders kyk, kos maak en gaan werk”. (P6; BT)

“When I woke up, I could not move my arm. I was scared, I am a man I need to look after my children, cook and go work”. (P6; BT)

The above statement describes the participant's fear of the diagnosis and fear when awaking to a disability. It presents her lack of education and insight about her stroke which she was unaware of as well as her prognosis. There is an urgency about returning to her motherly duties and to return to work. The participant felt a loss of control regarding the situation because now an altered identity came into play and it was infringing on their occupational roles. Further distress is

experienced by the lack of communication between health care workers and participants. One participant stated:

“Na die beroerte toe voel ek baie swak, niemand kon rerig vir my se wat gaan aan nie”. (P6, BT)

“After the stroke I felt very weak, no one could tell me what was going on”. (P6, BT)

The above statement shows that the participants are seldom clearly informed about their medical discharge. The statement shows that the participant was unclear about what exactly her diagnosis was and what it meant. The participants express that they needed to know what was going on as they had questions about their diagnosis and many of them wanted to know if they would be able to return to work and what the process would be if they wanted to do so. One participant stated:

“Ek het vrae gehad en ek wil geweet het of ek terug werk toe kan gaan, maar toe ek daar wegloop toe weet ek net dat ek moet na die arbidsterapeut toe moet gaan. ’n mens was nie gese nie hoe om terug werk te gan nie”. (P7; TB)



“I had questions and I wanted to know if I could go back to work but when I left (the hospital), then I knew I needed to see the Occupational therapist. It was not explained to me that I could return to work”. (P7; TB)

- **Temporary functional loss caused self-doubt**

These concerns stemmed from their loss of physical and cognitive functioning and not understanding that there was a chance that they would be able to return to work based on their functional baselines. Fear and frustration caused doubt in themselves and their ability to then return to work after functional loss.

“I just did get tired very easy, and I am a manager I can’t have that”. (P4: JL)

One participant felt that his fatigue will impact on his job description as his job required of him to be physical and included a lot of walking. The participant expressed that he would have to be mobile. Poor physical function had an effect on work and the ability of the participants to cope with the work tasks and overall job demand. One participant said:

“Mense het moeg geraak in die begin want ek het stadig gepraat en geloop. Hulle het nie verstaan nie. Hulle kon nie vir my verstaan nie” (P1; GW).

‘People got tired of me because I spoke slowly, and I walked slowly. They did not understand. They could not understand me’. (P1; GW).

During the early stages of the model participants who experienced physical deficits were more likely to not attend the program. It was observed that the participants initially would use their physical ability as an excuse to not attend the sessions. The participants initially felt that they would be a burden.

“The doctor told me I must go to occupational therapy and I said ok. I didn’t know what it was really, I also saw the physio en die psychologist at the hospital, Ek vat te lank om hospital toe te loop” (P4; JL)

As a result of this the participants would progress slower through the program than others. The participants with poor cognitive skills as a result of the stroke also impacted the rehabilitation process. The participants would take longer to understand and grasp concepts and to apply it therapeutically.

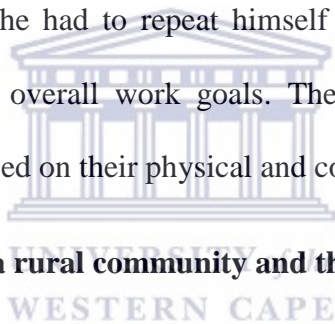
“Toe ek begin met die terapie, was ek stadiger as voorheen. Ek het lank geneem om die instruksies te verstaan” (P3; PK).

“When I started with therapy, I was slower than before. I took long to understand instructions”
(P3; PK).

One participant explained how as a result of his dysarthria during the beginning stages of his stroke people would become impatient. He said:

I am mos a man and now I am slower than before the lady mos didn't have time for that ai (P4; JL)

The above participant experienced difficulty when he needed to explain his vocational duties during the initial stages of MOOSE. He was also referred to a Speech therapist. He became quite frustrated and unmotivated when he had to repeat himself when he was not understood; this impacted on his job interest and overall work goals. The participants would evaluate their functional capacity and success based on their physical and cognitive deficits.



4.2.2 The perception of CVA in a rural community and the stigma related to CVA

In this category a participant expressed their experience and perception of stigmatisation about CVA in a rural community. One participant expressed his anxiety about returning to work after the CVA:

“Uhm, no..I just know some of the guys were worried that people might feel unsafe with me. But I can do the job, I mos went to the doctor, I did therapy I know how to feel when I am tired or stressed”. (P2; PK)

Participants were routinely subjected to comments on how easy it would be to stay at home and receive a salary. One participant felt especially forced to do so as his wife had lost faith in his work

skills and strongly encouraged him to apply for the grant as she felt he would never be capable to performing his previous vocational duties. He said:

“She just didn’t understand she said that I was never going to go back to work” (P3; JF)

Another participant stated that his brother had motivated him to apply for a grant instead of attending his therapy sessions. He said:

“They also on my case ek se about getting this grant a lot of them are on it mos, they say I must go to SASSA, I say no, then all I will do is sit at home and drink, that’s mos what we do in this town, get a grant, stay at home and drink”.(P2;PK)

Participants felt alone in the work place when colleagues doubted their work abilities and would describe the experience as lonely due to the lack of awareness in the overall community with regards to CVA.

“Die mense by die werk het nie verstaan wat a beroerte is nie. Baie mense het vir my gesê dat ek nie meer moet werk nie want ek is te stadig. Die mense in die dorp wil nie meer vir my hire om hulle huise skoon te maak nie want hulle was bang dat ek nie meer die werk kan doen nie” (P6; BT)

“The people at work did not understand what a stroke was. A lot of people told me that I should not work because I am slow. The people in town no longer want to hire me to clean their homes, because they were scared that I can no longer do the work” (P6; BT).

The participant’s work place often overlapped with their after work social life and majority of the participants felt left out and even left behind. One participant stated:

“Almal my vriende het my desert, Want ek kan mos nou nie meer saam gepraat het nie van die werk nie. Meeste van my vriende het ek meer saamgewerk” (P5; SL)

“All my friends deserted me, because I can no longer speak with about work. Most of my friends I worked with” (P5; SL)

The participants saw their social circles growing smaller and less people visited and invited them out. This resulted in participants questioning their own abilities as well as to consider the SASSA grant to somehow fit in and be accepted again even though they could and would eventually be able to return to work. One participant stated:

“Honestly, yes when the people left, and the hype dies down you still the one left alone with your stroke and your thoughts” (P4; JL)

Another participant started to feel the pressure to once again be included. He stated:

“Why don’t I apply for a for a SASSA (South African Social Security Agency) grant because my friend he mos has one” (P2; PK)

- **Impairments related to CVA contributes to unemployment of individuals in a rural sector**

Apart from being exposed to unfair treatment by family members and the community having a misconception on stroke, the participants faced a negative stigma in the work place. This was as a result of the misconceptions about a CVA sufferer’s behaviour and ability. As a result of this the participants felt that they should instead not return to work to avoid stigmatisation.

“Miskien gaan ek nie terug nie, miskien moet ek aansoek doen vir die grant” (P3;SL)

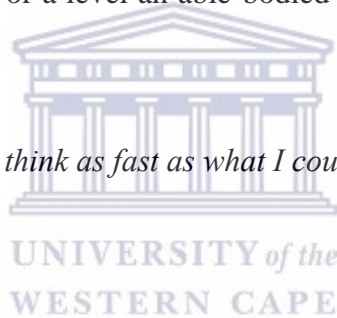
“Maybe I do not go back, maybe I should apply for the grant” (P3;SL)

The participants experienced attitudinal barriers from co-workers and supervisors which impacted their motivation to engage in vocational activities. As stated by a participant:

I can't give up what I worked for because people are talking behind my back, my boss he was glad to have me back and I wanted to be back" (P2; PK)

Due to the invisible deficits which the participants experienced as a result of the CVA, such as poor memory, the impairment was not taken into consideration and they were subjected to unreasonable work demands. Participants experienced instances where there were very few and no accommodations made within the work environment because participants were expected to perform at a level they once could or a level an able-bodied worker could. A statement conveys this:

"My memory and I was not able to think as fast as what I could, but I still had to take the minutes in the meeting" (P4; JL)



Participants became angered and unhappy about how their CVA was viewed by their co-workers. Some participants felt that they were seen as less and felt excluded as a result of this and how they were viewed in the working environment. As one participant stated:

" People are always going to skinner, everyday that's what they do. People just judge me they say I won't go back to work, I'm going to be like my brothers and get a disability grant. They want me to take a grant some of the men at work, hulle se ek is te stadig ek hou die werk op". (P2; PK)

Participants expressed that as a result of the manner in which they were treated at work there were numerous times that they felt they would give up their jobs, due to the lack of understanding in the community, work and home. The participants revealed that the support of the therapist was vital

in communicating with their bosses and that not everyone in the community who has had a CVA received such support which is why they never returned to work. One participant stated:

“I understand now why people in this place don’t go back to work, it’s hard. We must everyday struggle with our bosses because they don’t understand we must explain but we don’t also know. I was depressed and didn’t want to go back because of how the people were. Because no one is here to stand up for us then we rather leave the job and get the grant. It is easier” (P6; BT)

The participants conveyed that they would like to see a shift in the medical rehabilitation sector that would aid them to return to work. The effects of the stigma and marginalization impacts the person with a disability in their work environment to an extent that there is a risk of losing the person with disability from the workforce:

“Dit was baie moeilik want mense het aan hou vir my kom vra wanneer gan ek vir myself reg ruik, soes amper soes ek aan sit. Dit was nie lekker nie. Maar die slegste is as ek nie hier gewerk het nie, waar sou ek werk gekry het. Hier is nie werk nie en die plaas werkers drink te-veel”. (P5; SL)

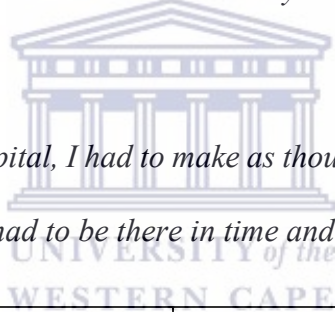
“It was very difficult because people kept on asking me when am I going to pull it together, like I’m faking. It wasn’t nice. But the worst is that if I didn’t have a job where would I have found one? There isn’t work here, and the farm workers drink too much”. (P5; SL)

4.3 Theme 2: Re-establishing a strong belief in functional ability through occupation

Theme two represents the participant's transition of the participants in the MOOSE program. It presents the regress and progress of the participants moving toward self-reliance/self-efficacy within the rehabilitation and work context. The MOOSE program was utilized throughout the rehabilitation process. The clinical goal of the model is that the participants who participate in it will integrate the work like behaviours, such as being punctual, adhering to the required dress code, employing good work ethic and achieving productivity.

“Toe ek by die hospitaal na die terapie gekom het, moes ek maak soos ek gaan werk, sien jy. Sodat dit kan wees as of ek regtig by die werk was. Ek moes betyds daar wees, en het tee gevat. Soos by die werk”. (P5; SL)

“When I went to therapy at the hospital, I had to make as though I was going to work, you see? So that it could be like it is at work. I had to be there in time and I took tea, like at work”. (P5; SL)



Theme Two	Categories
Re-establishing a strong belief in functional ability through occupation	<ul style="list-style-type: none"> • Rehabilitation was used as a means to improve competency through client centred activities • Holistic rehabilitation facilitates an improvement in motivation and belief in abilities

4.3.1 Rehabilitation was used as a means to improve competency through client centred activities

In this category the participants expressed that by participating in the rehabilitation program they were able to improve their workability skills. The program facilitated their recovery through activities which were based in each of their specific jobs. By applying the principles of client centred practice, the participants were to enhance their skills and knowledge to resume a worker role. By including the participants in the decision making with regard to rehabilitation they felt included and it allowed them to become part of a working community where they were able to make use of their work skills and apply what they have done in the program. One participant stated:

“I had to tell you what I like, so that you can make me feel included. I was very nervous when I came there, (laughs), uhm we did also or wait you did ask me what I do for a living like my work and so. You helped, because I got so tired after the stroke, I did feel like I had no energy, so you gave me tips, like to exercise or go for a walk. That helped, and it got better I don't feel like that anymore” (P1; GW).

As a result of including the participants in the process of planning work tasks their attitudes shifted toward a more positive outlook. They had started to accentuate the positive by sitting down with the therapist to plan their work goals. One participant stated:

“Ek het soos a mens gevoel (I felt like a person) I mean when do people ask you what you think is important, not the doctors and not my baas(boss). Nooit (Never)” (P2; PK).

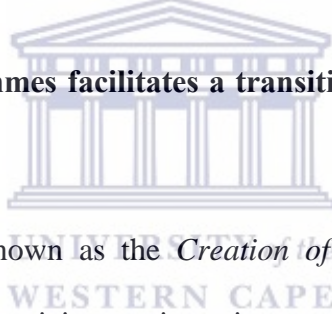
The participants' experience of attitude when returning to the community and being part of a team through simulated tasks performed at the hospital and at their places of work will allow them to

build onto their social relations, financial independence, self-respect as well as purposeful engagement through structured work tasks. A statement by one participant illustrated this:

“It was about helping me to return to work effectively and to ease myself back into my work setting. I enjoyed it because I was able to give my input and I could see it being incorporated which made me feel special and not like a child”. (P4; JL)

The above quote emphasises the participant’s need to be included in the therapy process and that it be client centred rehabilitation which speaks to the duties and functional skills they need for their work duties. It emphasises the importance of work to the participants and the need to feel included. It promotes a sense of who they are and builds onto an identity that was lost after the CVA.

- **Work rehabilitation programmes facilitates a transition to the client’s home and work environment**



Stage three of the MOOSE is known as the *Creation of competency through occupational engagement*. Within this stage the participants aim to improve their self-efficacy to such an extent that they would engage in work tasks independently. The participants were exposed to continuous practice in tasks such as marking wheelchair codes, working in the kitchen and simulated work tasks. The rehabilitation program focused on various components, which the participants needed to improve on after the CVA. These components were also work related to improve their work skills and to enhance their prospects of returning to work. One participant stated:

“The support and reassurance that you gave and also that I felt included in therapy. You also gave me things to do that worked and was easy to apply at home and work “(P4; JL)

By engaging in simulated work tasks before the participants returned to work aided them in improving their self-belief and regaining their functional capacity. One participant reported:

“My memory and I was not able to think as fast as what I could, which is why the activities and home programs which you gave helped me so much. I needed it for my job, so the things were applicable you know?”. (P4; JL)

By participating in the work-related tasks, the participants were able to improve their self-efficacy. It aided in their ability to improve their capability through engaging in meaningful occupations. One participant stated:

“I just felt better about the whole situation and going back to work because I was able to see what I can do. Working was nice or practicing to work was nice. Now I go back and feel lekker because I know how I became better” (P7;TB)

- **Simulated work tasks enable work reintegration**

Due to the frustration and anxiety the participants felt as mentioned previously it was vital to ensure that they feel secure in their work occupations. The participants were exposed to compensatory methods and encouraged to utilize strategies to improve their physical deficits and memory with strategies such as recalling activities or retaining relevant information. One participant said:

“You helped, because I got so tired after the stroke, I did feel like I had no energy, so you gave me tips, like to exercise or go for a walk. That helped, and it got better I don’t feel like that anymore”.
(P1; GW)

During the transition phase from stage 3 to stage 4 of the Model the participants reintegrated back into the work place by working shorter periods of time at their places of work. The therapist together with the participants facilitated the return to work process by liaising with the companies and the participants Human Resources Departments. One participant stated:

“Die arbeidsterapeut het met my baas gaan praat, en toe besoek ons die werk saam, uhm wag gou, uhm en en toe verduidelik sy wat ek nodig het om terug te gaan, en dat ek `n ander tipe werk kan doen. Net om myself te beskerm. Ons het saam gewerk om my te laat terug gaan werk toe, sy het kom sien hoe dit by die werk gaan en sy het vir my beklei dat ek weer kan gaan werk” (P5; SL)

“The Occupational therapist went to speak to my boss and she went to visit my work with uhm, wait quick, uhm and, and so she explained that I need to go back to work and that I can do other jobs. Just to protect myself. We worked together to help me get back to work. She came to see how it went at work and she fought for me so that I could go back to work”. (P5; SL)

As part of the RTW process, the participants engaged in activities which prepared them for work placements, social presentation and interviewing skills. The participants reported they were eager to return to their previous work tasks they were previously engaged in. A participant stated that he was excited to be able to go back to work. He stated:

“Ek ry nou weer, maar net korte afstande. Soes 90 km of 100 km vir die meeste. Dit is lekka want nous nader ek het meer tyd met die familie”. (P2; PK)

“I am driving now again, but just short distances. Like 90km or 100km is the most. It is nice because now it’s closer and I have more time with my family”. (P2; PK)

Another participant not only felt the excitement to return to work but also valued the social interaction he would have with his fellow work colleagues. The participants expressed that they needed to return to work to be able to provide for their families which provided them with great motivation to engage in the MOOSE. He stated:

“Vir my is dit ‘n belangrike deel van die lewe. Ek verdien nie baie geld nie maar dit wat ek kry waardeur ek baie. Te werk is lekker, ek hou van mense soe om met mense te werk en vriende te sien is goed vir ‘n mens”. (P4; JL)

“For me, it is an important part of like (work). I do not earn a lot of money, but what I do get I appreciate. To work is nice, I like people, so to work with people and to see friends is good for a person”. (P4; JL)

4.3.2 Holistic rehabilitation facilitates an improvement in motivation and belief in abilities

Due to the CVA affecting various functionalities of the participants, physically, psychologically and spiritually, they were treated holistically. For the participants to have an effective return to work their home and work contexts needed to be taken into consideration. By making use of the allied health team the participants were not only attending Occupational Therapy to improve their functional capability and self-efficacy, but they attended Physiotherapy, Speech Therapy and Psychology as well.

This sub-category is indicative of how these services affected their motivation and belief in abilities which enabled them to engage in their vocational duties effectively.

“The doctor told me I must go to occupational therapy and I said ok. I didn’t know what it was really, I also saw the physio en die psychologist at the hospital” (P4; JL)

- **A multidisciplinary approach was used to ensure that the participants were treated holistically.**

Participants experienced various symptoms as a result of the CVA as mentioned previously, however to fully ensure that the participant reached a level of optimal capability they not only

needed to attend Occupational Therapy. A referral process takes place once a participant is admitted into the hospital and upon discharge they are then seen on an out-patient basis. With this type of rehabilitation, the participants were provided long term clinical input from health care workers. A participant was a Pastor in the church and he regularly led the church services. After his stroke he suffered from Aphasia and was seen by a Speech therapist. During the initial phase of his CVA he felt demotivated and as though he would not be able to return to work as being a pastor was his main Occupation and source of income. He stated:

“Maar ek weet miskien is daar a kans dat ek nie meer kan preek nie”. (P1; GW)

“But I know that there is a chance that I won’t be able to preach again”. (P1; GW)

He explained further:

“Ek..het elke Donderdag spraakterapie bygewoon en geleer hoe om beter te praat en..en hoe om meer duidelik te praat”. (P1; GW)



“I attended Speech therapy every Thursday and I learnt how to speak better and how to speak clearer”. (P1; GW)

The retardation of his speech not only affected his ability to perform his job but also his home and social context. He stated:

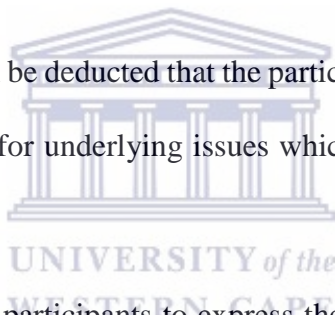
“Ek dink dit is omdat ek a bietjie stadig nou praat niemand het meer tyd vir my nie. Ek praat swaar. Dit het met my gebeur, ek moet elke dag met dit lewe. Nie hulle nie.” (P1; GW)

“I think it is because I speak slower, and no one has time for me anymore. I struggle to speak. It happened to me, I must live with it every day. Not them”. (P1; GW)

Due to their perceived disability participants often felt isolated but by engaging in therapy from various allied health professionals they felt more confident to return to their work contexts. The CVA affected home context and due to the changes, which came with the diagnosis participants and their families would find themselves struggling to deal with the change, often causing family conflict and creating a negative environment. Often there was marital conflict and in these cases the participants were referred for psychological intervention:

“I was very, uhm stressed, everything was just falling apart. Things at home wasn’t lekker, my wife and me, we did just fight all the time. I am mos ‘n man and now I am slower than before the lady mos didn’t have time for that ai.” (P4; JL)

Based on the above statement it can be deduced that the participants felt emasculated and stripped of all roles and needed to be seen for underlying issues which might have been brought on as a result of the CVA.



This provided a safe space for the participants to express themselves freely. Key informant one stated:

“Once they (Participants) could see they were improving in counselling sessions and their physiotherapy sessions they were more willing to face the RTW process. They engaged more in the program with eagerness”. (Key informant one)

By attending the therapy needed and witnessing their improvement, participants displayed enthusiasm in the program and expressed their excitement to return to work. One participant stated:

“I was so excited to get back to work. I just wanted to work for myself, earn my money. It’s so difficult to find a job that I am proud of in this small town. I mean when this type of thing happens to a person, then you think, yoh, how now, but I just want to do what I worked hard for. Yes, it was

difficult to go back. I was worried that I will not be able to do what I could, but we worked hard to find ways to help me do the job”. (P7; TB)

- **Understanding diagnosis is essential for accurate work placement and work rehabilitation**

In the initial stages of the Model it was evident that the participants were not fully informed of their diagnosis and how it could possibly affect their futures. Participants were under the impression that they would not be able to return to work. One participant conveyed:

“She (wife) just didn’t understand what the doctor said, she said that I was never going to go back to work” (P4; JL)

Lacking the knowledge regarding their diagnosis, the participants would express personal uncertainties about their understanding of what a CVA was. Although the education that the participants received in the intervention sessions focused on the negative effects of medication and stroke not much emphasis was placed on the possible functional improvement they could have. Participants found difficulty relating their diagnosis to the symptoms they experienced and its connection to the functional fallouts they experienced in their occupations.

“I work on the road works, I am part of a team and I am head of that team. So, at the stop and goes, I must make sure that everything runs smoothly that the cars don’t knock each other. That everything is working, the signs must be right, but I struggled because I didn’t know if I can do it anymore” (P4; JL)

The participants were educated on what their diagnosis was in the sessions they attended with the various allied health professionals and how it will affect their daily lives. The program focused on how it would affect the participant holistically and very importantly how it would affect their work

roles. By understanding their functional capabilities participants were able to gauge if they would be able to return to their previous vocational duties or if reasonable accommodation would be needed. One participated stated:

“Ek kan ander goed ook leer doen. Soos die opofferings geld tel, en ’n klien gedeelte van die preek doen. Ek kan ander goed ook leer doen. Ek hou van wat ek doen. As ek dit nie doen nie. Dan gaan ek voel soos, what doen ek nou?” (P1; GW)

“I can learn to do other thing like counting offerings and a small portion of the sermon. I can also learn how to do other things. I like what I do. If I can’t do it, then I feel like what am I going to do now?” (P1; GW)

Based on the participants’ functional abilities they were able to be placed into a job which allowed them to perform to the best of their capabilities. The participants engaged in tasks that would enable the therapist and the human resource departments to allocate the participants in their previous jobs or accommodated job tasks. In doing so the participants were able to understand why they were given other duties in the work place. One participant stated:

Because we spoke to my boss they were able to help us find another job for me to do but I still get to work for the same company, the boss didn’t throw me away. It shows they actually care. (P5; SL)

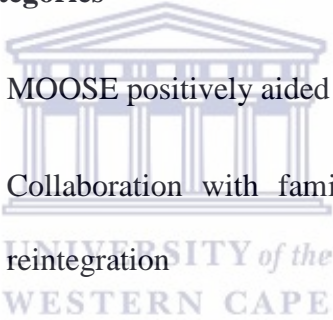
By communicating with the participants and their respective bosses, the participants felt a sense of relief and as though they were being accommodated in the work place. The participants expressed that it was that returning to work was a priority for their financial stability. Participants were excited to know that even after the CVA they would be able to return to work. One participant stated

“I can’t give up what I worked for because people are talking behind my back, my boss he was glad to have me back and I wanted to be back” (P4;JL)



4.4 Theme Three: Adaptation strategies that enhances the work participation of stroke survivors in a rural community

In the program participants not only engaged in activities to assist their return to work, the participants were also educated on various adaptation strategies they were exposed to in the MOOSE program. It was important that adaptation strategies were context specific and were easy to apply for the participants. Theme three also describes the impact of the liaison between Occupational Therapist, participant and employee.

Theme Three	Categories
Adaptation strategies that enhances the work participation of stroke survivors in a rural community	 <ul style="list-style-type: none"> • MOOSE positively aided in returning individuals to their work role • Collaboration with family and employers contributes to work reintegration

This theme focuses on the adaptation strategies the participants applied when they returned to their home and work contexts. It explores the activities they engaged in through the model and how this aided them in their return to work process. It gently touches on how the participants grew through their engagement in occupation and through occupations they were able to slowly piece together bits of their previous selves.

“We did learn how to bend and pick up heavy goed (objects), and how to make the work space better” (P1; GW)

4.4.1 MOOSE positively aided in returning individuals to their worker role

In this category the participants express the adaptations which they have made in the Model through engaging in activities. Participants express their experiences of the activities they engaged in and what type of activities they engaged in which prepared them to return to work. This category aims to depict the transformation the participants went through by participating in the MOOSE model and how it positively aided them into their worker role. This category will illustrate how participants transformed and how they adjusted to the emotional, physical and cognitive changes and how this contributed to developing an internal need and drive to adapt themselves within their daily work occupations.

- **Exposure to structure and income through the MOOSE program**

Once participants were discharged many were given sick leave for a 3- 6 weeks period from their respective places of work. This gave them a period of time to recover and attend therapy sessions regularly. In this period participants were engaged in simulated work tasks where they came to therapy as a “job”. During the rehabilitation period they focused on performing simulated tasks which related to the various vocational duties they would assume when they return back to work. This aided the participants and therapist as it would provide clarity as to if the participants return would they be able to return to their previous duties or would reasonable accommodation need to be arranged. A participant said:

“Ek het elke tweede dag van die week in gegaan hospitaal toe vir 6 weke. Ek mos ure in werk na my sessies by die terapeut. Toe soos ek verdeidelik het moet ek in die stoor werk, tuin spuit of maak soes ek tuin spuit want hier is niks water nie”. (P5; SL)

“I went in every second day to the hospital for six weeks. I had to work in hours after my sessions with the therapist. Then like I explained, I have to work in the store room, water the garden or pretend I am watering the garden because here is no water.” (P5; SL)

Throughout the rehabilitation process, return to work goals were developed with the participants, their performance skills and work components were remediated to restore and establish occupational skills.

“I had to clock in at 8 the morning and I helped the cleaning staff do the washing and wash the floors. It wasn't nice when I did it first time because I was slow, but now I see I can do it and it makes me happy” (P6; BT)

The participants expressed their individual construct of the purpose and meaning that work brings to their lives. To some it was the financial gain and to others it was being able to simply provide for their families. One participant expressed that although he does not earn much he was “proud” to work in an area where unemployment was rife.

“In this place there isn't a lot of jobs. When I work then I know I am earning my money, I have so much to be thankful for, and the Lord knows we struggle with jobs in this town. To work is like a blessing” (P6; BT)

Participants also reported that attending the program (vocational intervention) and getting a sandwich every day in the program made the work environment feel more realistic and as though they had a purpose. One participant said:

“Elke dag getydens lunch het ons a toebroodjie gekry, dit was lekker, gevoel soes ek by die werk is weer. Dit het die tydjie wat ek nie gewerk het nie laat okay voel, want nou doen ek iets om my omstandigheide te vebeter” (P7, TB)

“Every day during lunch time I got a sandwich, that was nice. It felt like I was at work again. It made the time that I was not working feel okay. Because now I am doing something to better my circumstances”. (P7, TB)

The participants reported that being in a work like environment and exposure to a work structure had a positive impact on their work performance. A participant stated:

“Ek moes ook al die rol stoele met en hul nommers af skryf. In die begin het ons aan my hand baie gewerk en ook my spraak. Dit help want nou voel ek gereed om te werk”. (P5; SL)

“I also had to write down the wheelchairs and the numbers of the wheelchairs. At the beginning we worked on my hand and speech. It helped prepare me for when I go back to work”. (P5; SL)

- **Compensatory skills to cope within the workplace**

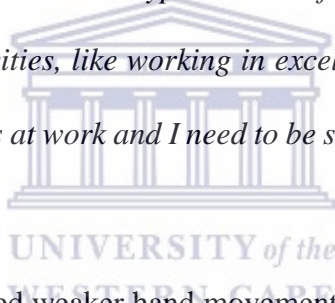
The participants reported that they were educated on compensatory skills within the MOOSE program. Participants reported that they were able to utilise the practical compensatory skills they were taught during the rehabilitation process. The participants were introduced to a wide range of skills which they would be able to apply in both their home and work contexts. Participants were exposed to a range of compensatory skills, such as work simplification, public speaking skills, time management and controlling emotions. Most of the participants engage in physically demanding jobs and required to be taught skills which would relieve physical stress on their bodies. A participant who is a driver required assistance at the start of the rehabilitation program with short term memory. To ensure a positive return to work experience he engaged in cognitive activities with assistance from a driving assistant. He said:

“I had to explain how to get to places. I had to show him (driver) how to look for petrol stations (landmarks), or a farms name. But I know this place like the back of my hand. And I got upset at

the start because I thought why must I do this therapy, I know this place better than anyone. But as I was doing it, it was helping me. But now I'm back at work, I drive shorter distances, but it is good. Now I use a map if I forget and I learned how to remember the landmarks". (P2; PK)

Participants required assistance with time management after the stroke due to the stroke which had delayed their work abilities. The participants needed to use time management to complete all their tasks at work instead of taking on too many tasks at once. One participant is in charge of a business which requires him to do most of the administrative tasks. The participant said:

"Well, we looked at managing my time better, also gave me activities to test my cognitive skills. I needed to give you an example of a week or a typical week of mine and looked at how to adjust it. We also did some calculating activities, like working in excel and making sure numbers balance because I am in charge of the books at work and I need to be sharp to do it, that helped a lot" (P4; JL)



Another participant who experienced weaker hand movement due to the stroke explained that the exercises given to him aided him to write his name again when he thought he would not be able to. He expressed:

"Ons het met hand oefening begin want na die beroerte toe kon ek nie eers skryf nie. Ek kan nou my naam skryf, vir 8 weke het ons die hand oefeninge gedoen en dit het my baie gehulp. Ons het ook met daardie klein sunlight en shield goed gewerk, ek moes se waar ek dit gebruik" (P5; SL)

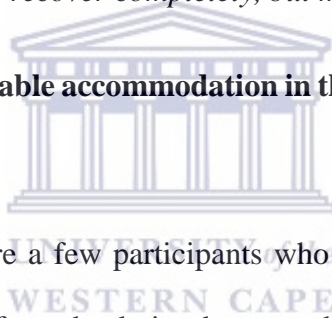
"We started with hand exercises because after the stroke I could not write. I can now write my name again, for eight weeks, we did the hand exercises and that helped a lot. We also made use of the small sunlight and shield stuff and I had to say where I would use it". (P5; SL)

Participants who were not able to return to their previous work tasks due to their disability and were worried about their income were taught money management skills. A participant said:

“Elke een van daardie goed het ‘n prys aan gehad. Toe mos ek dit gaan “koop” het in die winkel. Dit het my geleer hoe om met geld te werk. Toe ek ‘n bietjie beter geraak het, het ek die mense in die stoor help bokse tel. My hand het nie heelte mal reg gekom nie. Maar my brein het vebeter”
(P5; SL)

“Every one of those things had prices on them then I had to go “shop” for them in the store. It taught me how to work with money. When I got a little better, then I helped the people in the store room count boxes. My hand did not recover completely, but my brain got better” (P5; SL)

- **Reintegration through reasonable accommodation in the workplace facilitates workplace adaptation**



As a result of the CVA there were a few participants who were unable to return to work and resume their previous roles and perform the duties they once had fulfilled. Despite the participants not being able to resume their previous roles they had learned how to fulfil duties similar to what they had done previously. Participants expressed contentment however since they were effectively delivering a service and gaining an income. One participant stated:

“I am earning money, being a pastor is what I became, it was my choice. I am giving people something and it helps me also to be positive, uhm, to also take a message home after I preach”.
(P1; GW)

Another participant owned his own mechanical business which he had run with his two sons. The participant had to come to terms with the idea that he no longer could perform the mechanical duties which he previously used to help with. The participant stated:

“I am more focused on the admin side of the business. I ensure that all the books are up to date and to promote the company”. (P4; JL)

Adaptations needed to be made to facilitate the reasonable accommodation into the participants’ new roles and duties: One participant stated:

“I know now that I wouldn’t be able to do the heavy lifting anymore because you see what happens is that I am impatient and when I see that my employees are not working well, I just jump in and do it myself, I’m not supposed to, but I do. I can do it yes, but it is advised by the doctor that I should not do it anymore”. (P4; JL)

4.4.2 Collaboration with family and employers contributes to work reintegration

The participants found that the integration back in to the work place would not be an easy task if they had facilitated the transition independently. By informing the participant’s families on the physical, cognitive and work ability changes after the stroke the participants were able to receive support and encouragement from family while returning to work. Through consistent communication with the employers they were able to be informed constantly regarding changes in the participant’s progress with regards to work ability.

- **Communication with employers facilitates successful work place reintegration.**

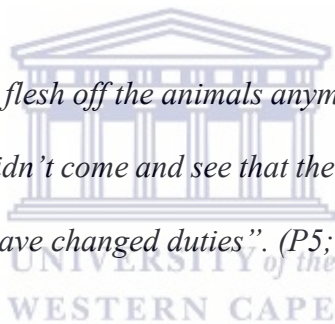
Through communication between employer, employee and Occupational Therapist it allowed for a safe and timely return to work. Using the participant’s functional baseline, the therapist was able to communicate effectively tasks that the participants were capable of performing to ensure safety. The participants expressed concern regarding their capability upon their return to work. One participant echoed this sentiment:

“I was negative yes but for me there is no option about working, I have put my life into this business and I needed to go back”. (P4; JL)

- **Work site visits enhances an understanding of a client’s vocational duties**

The participants expressed that it was vital for them to return to work as they needed it to survive financially and to support their families. It became clear that the participants needed support through the transition from therapy to work. This was facilitated through work site visits done by the Therapist to assist in the support of the participants. It also provided the Therapist with an opportunity to assess whether or not the reasonable accommodation was feasible. One participant said:

“We went to my job, I don’t cut the flesh off the animals anymore. I just wash it off once everyone is finished with the cutting. If you didn’t come and see that the other job was too heavy for me then I don’t know if I would be able to have changed duties”. (P5; SL)



By arranging the work site visits, it allowed the therapist to observe whether the participants were able to apply the precautions and skills performed in the rehabilitation program. In doing so the participants felt more comfortable to return to work and expressed they felt more secure and prepared to return to work. One participant stated:

“I understand now why I had to do it. I had to come to therapy, it’s like becoming a new me”. (P2; PK)

A vital part of the program was for the participants to engage in context specific activities. The activities needed to be sustainable which they could utilise in their work place and in their homes.

“The support and reassurance that you gave and that I felt included in therapy. You also gave me things to do that worked and was easy to apply at home and work” (P4; JL)

- **Family members as an important form of support to facilitate the reintegration of an individual into the workplace**

It was vital for the Therapist to include the participant’s family members in the therapy process. By working with them and educating them on the CVA diagnosis, it provided the family with a better understanding about the return to work process. As mentioned previously due to the lack of understanding participants felt immense pressure from their family to apply for a disability grant. This stemmed from a concern that the participants would never have the ability to return to work.

One participant stated:

“I was very, uhm stressed, everything was just falling apart. Things at home wasn’t lekker, my wife and me, we did just fight all the time. I am mos a man and now I am slower than before the lady mos didn’t have time for that ai” (P4; JL)

By including the participant’s families, the participants felt more support from their families as they started to understand that through rehabilitation the participants would have a better chance to return to work and have an income which was more practical than the SASSA grant. The participants expressed that their spouses or other families were worried that they would not be able to support their families financially in the time that they were at therapy. This created a barrier.

One participant stated:

“Hulle het nie verstaan nie, gedink ek sal nooit weer kan werk nie, hulle het nie verstaan hoe dit werk nie. Maar toe my familie saam met my terapie toe gegaan het, het hulle gehoor dat ek kan

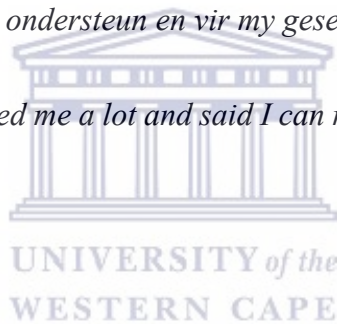
dit doen. Ek kan nog werk. Dit het baie gehelp. Ek het goed gevoel toe ek weer gaan werk het. Na die sessies het hulle my ondersteun” (P6; BT)

“They did not understand, they thought that I would never be able to work again. They did not understand how it worked. But when my family went with to therapy with me they heard that I can do it. I can still work. It helped a lot. I felt good when I went back to work. After the sessions they (family), supported me”. (P6; BT)

The participants felt more supported once their families understood and the participants expressed that they felt more motivated once their families showed them support.

“Ek wil net sê my vrou het my baie ondersteun en vir my gese ek gan deur dit kom “(P5;SL)

“I just want to say my wife supported me a lot and said I can make it through this situation”. (P5; SL)



Theme four: The MOOSE enables transition to the worker role in a rural context

Theme Four	Category
The MOOSE enables transition to the worker role in a rural context	<ul style="list-style-type: none">• Enhancing skills by participating in MOOSE• Strategies for enhancing the MOOSE• Environmental adaptations

Throughout the MOOSE program the participants were encouraged to reflect on their experiences during and after sessions. By doing this the participants were able to identify their growth in the program. Through self-reflection the participants were able to identify which areas they felt they needed more focus, such as being able to recognise when they became overwhelmed or stressed. This allowed for issues which might cause participants to be non-compliant to therapy, to be addressed.

“I had to write down my stress in my book I must see what I can control and what I can’t”
(P1; GW)

4.5.1 Enhancing skills by participating in MOOSE

Through participating in the MOOSE program, the participants were able to acquire new skills based on the personal contexts. The participants engaged in not only simulated work tasks but were educated on how to handle stress factors in their lives which might affect their home and work contexts. One participant stated:

“The OT did teach us how to bend and pick up heavy goods (goods), and how to make the work space better. You helped, because I got so tired after the stroke, I did feel like I had no energy, so you gave me tips, like to exercise or go for a walk. That helped, and it got better I don’t feel like that anymore”. (P3; JF)

Through the engagement in physical activity the participants were able to adapt their environments to make it more ergonomically safe, allowing it to cause less strain on their bodies.

Another participant echoed this:

“Ek het geleer hoe om my tyd te werk. Nou waneer ek kerk moet gee, beplan ek wat ek wil sê in die diens vooraf soes ons in die sessies dit geoefen het” (P3; JF)

“I learnt how to work better with my time. Now when I have to preach at church, I am able to plan better and plan what I want to say in the service like we did in the sessions”. (P3; JF)

The skills taught in the program were aimed at ensuring that the participants were able to maximise their occupational self-efficacy by educating them on time management as well as budgeting. These are skills participants could make use of at work and in their home contexts.

The participants felt as though all their occupational areas such as work, home and social contexts were being addressed in the sessions. It was identified by the participants that the strokes were caused by stress, the participants were then taught relaxation and stress management techniques to apply when in a stressful situation at work or at home. One participant stated:

Well, we looked at managing my time better, (The name of the therapist were removed for ethical reasons) also gave me activities to test my cognitive skills. I needed to give therapist an example of a week or a typical week of mine and looked at how to adjust it. We also did some number

activities because I am in charge of the books at work and I need to be sharp to do it, that helped a lot (P4; JL)

- **An improvement in work skills facilitates confidence in returning to work**

As mentioned previously by not engaging in work related tasks and being able to provide for their family's participants expressed shame and lack of self-confidence not being able to perform the roles they once could. By engaging in tasks directly related to their work tasks the participants expressed that they felt more confident when having to return to work. One participant stated:

“Dit het vir my laat goed voel. Baie goed”.(P3;JF)

“It made me feel good, very good”. (P3;JF)

By improving and adapting their task methods the participants expressed that they were able to return to work feeling confident and more capable. Through engaging in work specific task and simulated work activities, improved the participants work methods. The participants felt prepared when they were placed back into the work environment and left the participants feeling less anxious about their return to work process. One participant expressed:

“I feel very happy, because why it helped me a lot in my work and home”. (P2; PK)

The participants each fluctuated through the stages of the MOOSE, some progressed and some regressed but they all found new skills which they could implement at work and at home which directly influenced their overall well-being. One participant explained:

When I was finished at the hospital and I went back to work, I really just wanted to shout because I was so happy. I just felt at peace. I overcame a hectic situation and now I am an overcomer, even though I know I must still work on myself. I know more now that what I did. (P7; TB)

Another participant stated:

“As I said earlier it helped me ease into the process of work and aided me to implement new ways of doing things”. (P4; JL)

4.5.2 Strategies for enhancing MOOSE

Occupational therapists play an integral role in enabling ongoing participation by optimising function and management of symptoms. Occupational therapists working with people receiving palliative care acknowledge the dual reality of living and dying and work within this context. for enhancing the MOOSE.

To ensure that this model is effectively used in practice, specifically in the rural context recommendations were suggested by the participants. This will ensure that the model can be used in various contexts and thus making it universally applicable in clinical settings.

The participants felt that the model was flexible and easily applied in the sessions, more than that it was context specific. However, as the program is six to eight weeks the participants became anxious as they were concerned that their employers were not going to understand that they were booked off from work. One participant stated:

“Hulle kan nie verwag dat almal se baas sal gelukkig wees as hulle vir soe lank af vat nie. Want nou vat ons af, wie gaan ons betaal. En die hospital kan nie en gaan nie vir my dieselfde pay gee nie as wat my baas dit doen nie”. (P2; PK)

“They can’t expect that everyone’s boss will be happy that they take off from work for so long. Now we take off work then who is going to pay us. And the hospital isn’t going to give me the same pay as my boss does”. (P2; PK)

It became evident that the participants were concerned that they would not get paid if they attended the sessions. One participant expressed:

“Ek maak die huise skoon, as ek nie ‘n huis skoon maak nie dan word ek nie betaal nie. One het nie goed soos kontrakte nie” (P6; BT)

“I clean homes, if I do not clean the house then I do not get paid. We do not have things like contracts”. (P6; BT)

The concern stemmed from the fact that the participant did not have a work contract which would aid her in getting paid despite her having a medical reason why she could no longer attend work.

The therapist made provision for those participants who could not afford to bring bread to the sessions for lunch as they would spend 6-8 hours engaging in the program. A participant explained:

Ek kan eerlik sê niks nie, sy (terapeut) het alles met my gedoen, sy het my gehelp en dit maak die program baie lekker. Die broodjies was ook lekker (laughs). Ek is net dankbaar. (P5; SL)

“I can honestly say that I wouldn’t change anything, she (therapist) did everything with me, and she helped me and that made the programme nice. The sandwiches were nice. I am very grateful”. (P5; SL)

4.5.3 Environmental adaptations

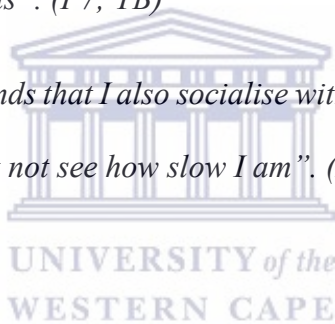
Privacy was very important to some of the participants. The area in which they had to engage in simulated work were an open area and often other patients would walk through the area. This caused some participants to become frustrated as it made them not want to attend the sessions. As a result of the latter, their sessions were often conducted in their place of work or moved to their homes.

“I didn’t like that I had to wait in the waiting area and everyone would look at me and ask me if I’m there because of the stroke” (P4; JL)

As a result of the area where in the hospital is situated being small and very close-knit participants found it difficult to work in the hospital as the majority of the participants knew the employees at the hospital. They would live in the same area that the participants lived and in their social groups. The fact that everyone lived so close made the participant’s feel embarrassed and self-conscious. One participant stated:

“Ek wil nie met my vriende met wie ek kuier werk nie. Dis net weird. Is daar nie ‘n ander plek nie? Almal moet nou sien hoe stadig ek is”. (P7; TB)

“I do not want to work with the friends that I also socialise with. It is just weird. Isn’t there another place we can work? Everyone must not see how slow I am”. (P7; TB)



As the sessions continued the participants became more acceptable of their condition and were not as afraid to work in the hospital and return to work. A participant stated:

“I feel very happy, because why it helped me a lot in my work and home I just hope that everyone will get what I got and see how it can help when you do the therapy and if you work together with the people because they also want you to get better”. (CVA1, pg4)

4.6 Summary

Based on the chapter’s findings regarding the participant’s experiences and perceptions about vocational rehabilitation and their views on return to work in a rural community, there has been an attempt to answer the objectives of the study. Theme One described the participant’s experiences

and perceptions of the barriers that hindered the resumption of work for stroke participants in a rural community.

Theme Two focused on describing the experiences and perceptions of the participants regarding factors that facilitated the return to work process. Theme Three presented the participant's experiences and perceptions of the adaptation process and the adaptation strategies that would enhance the work participation of stroke survivors in a rural community. Theme Four described the experiences and perceptions of the stroke survivors regarding the vocational model which the participants engaged in. Theme Four also described possible strategies rehabilitation professionals could utilise to further develop the MOOSE in the field of vocational rehabilitation and work integration for stroke clients. (See *Figure 2* that describes the interrelation between the themes)



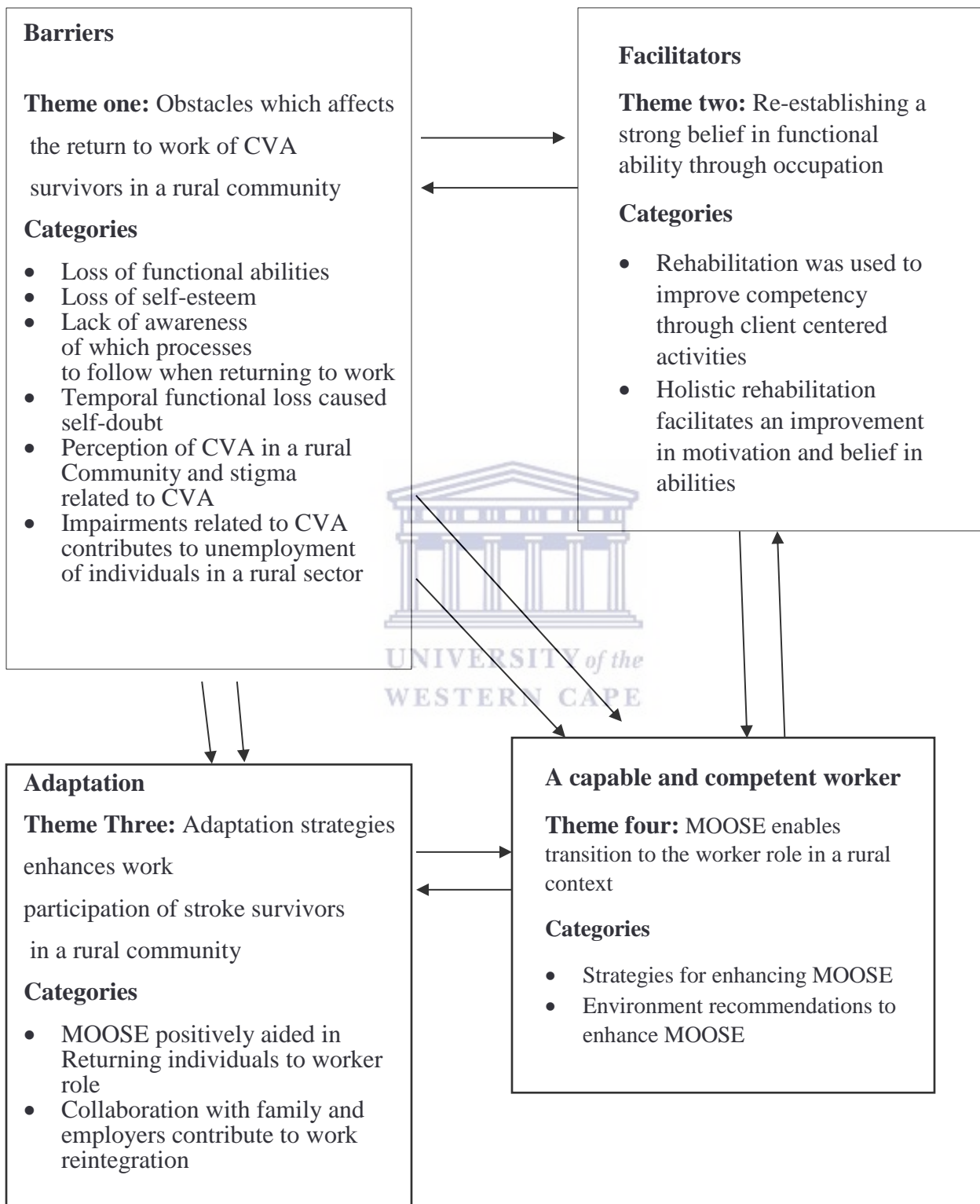
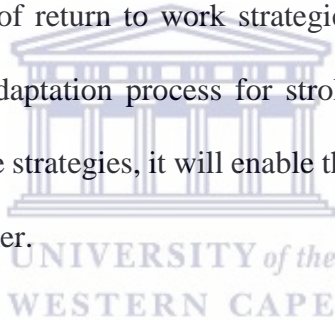


Figure 2: Diagrammatic representation of themes and categories

The diagram (*Figure 2*) on the previous page depicts the relationship between the various aforementioned categories.

Description of the interrelation between themes

When the integration of the facilitating factors counters the barriers faced by the participants then the adaptation process is deemed successful. Contrary to the former statements, if the barriers are then too challenging and the facilitating factors too frail to overcome the barriers, then the adaptation process is not achieved. Therefore, in Theme Four of the current chapter, additional development and implementation of return to work strategies are described which will further enhance the success rate of the adaptation process for stroke patients/clients living in a rural community. By implementing these strategies, it will enable the stroke survivors to return to work and thus become a competent worker.



CHAPTER FIVE: DISCUSSION

5.1 Introduction

In Chapter five the factors which influence the return to work of stroke survivors in a rural community is discussed. The aim of the study is to describe the experiences and perceptions of individuals diagnosed with stroke about the usefulness of the MOOSE in assisting them in returning to their worker role particularly in a rural community setting. In this chapter there is a discussion on how MOOSE enabled the participants to overcome challenges once the participants returned to their vocational duties which relates to the first objective of the study which aimed to describe the experiences and perception of individuals with stroke regarding the usefulness of the MOOSE in the facilitation of the work transition. The chapter will also discuss the challenges the stroke participants experienced after the stroke in a rural community, it will explore the barriers and facilitators that affected the participants during the vocational rehabilitation period and after return to work relating to the second objective, to describe the experiences and perceptions of individuals with stroke about how their worker identity has changed after participating in the MOOSE. The adaptation process which relates to the third objective, to describe the experience and perceptions of individuals living with stroke about how the MOOSE enabled them to adapt to their worker role in a rural setting is discussed highlighting the relationship between occupational self-efficacy and occupational adaptation. Finally, there is a discussion on the possible strategies for future enhancement of vocational rehabilitation programs using the MOOSE for stroke survivors in a rural community.

5.2 Usefulness of the MOOSE in facilitating the transition to the worker role

In the sections that follow the Barriers and Facilitatory factors that contributes to the implementation of MOOSE will be discussed. This section of the study will specifically relate to *objective 1* of the study.

5.2.1 Barriers related to the implementation of MOOSE in the workplace

According to the World Health Organisation (2016), barriers are defined as the factors which are present in an individual's environment that may limit their functioning. In Theme One, the participant experienced barriers which stemmed from the stroke. The stroke caused functional limitations to return to productive work. Various barriers such as negative stigma, marginalisation, lack of knowledge and attitudes within their home contexts and work environments hindered the reintegration of stroke survivors. Based on the definition of barriers by WHO the participant experienced strong similarity with factors identified by the WHO.

5.2.2 Barriers to work participation for Stroke survivors in a rural community

The participants experienced a negative change in their functional performances after the stroke, some worse than others. Once the stroke occurred they came to realise that tasks and activities which they could once perform, before the stroke, they could no longer perform as efficiently because they had lost former knowledge and abilities. According to Burkman (2010), one of the biggest fears, for both patients and families, is the fear of the unknown. As well as “what to expect?” and “what happens next?”. Burkman (2010), further explains that for the majority of stroke patients, the road to recovery is a long one that includes many hours of therapy aimed at restoring both physical strength, language capacity and often not considered medically, a loss of self-esteem (Burkman, 2010).

Participants battled to progress past the initial stages of the stroke due to lack of knowledge and a limited true insight into the impact of the stroke on their functioning. Furthermore, it was discovered that as a result of the former the participants were unaware that once they go through rehabilitation there was a possibility of returning to work. The participants struggled to comprehend the magnitude of their current functional limitations and abilities, this in turn impacted on their emotional state and motivation to move forward with their lives. Kielhofner (2009) describes “self-efficacy as one’s perception of self-control and how much one is able to bring about what one wants”. The participants stated they no longer felt in control and this led to them becoming frustrated. Kielhofner (2009), elaborates further and states that a strong sense of efficacy is impossible if one believes that one is challenged by overwhelming emotions and uncontrollable thoughts.

5.2.3 Loss of Self-esteem

After the stroke the participants expressed that it was difficult to cope with their injury and that they were afraid they would not be able to return to work, not be able to provide for their families. This hindered their motivation to return to work not knowing what their capabilities would be once they completed their rehabilitation program. According to Musser et al. (2015), sociological theory points that individuals who hold multiple identities (i.e., worker, neighbour, friend, parent, spouse, etc.) may be more resilient after injuries such as stroke.

By engaging in meaningful work related the occupations in the rehabilitation process and once they return to work, it was evident that they were regaining self-esteem, and felt more confident to take on tasks in the work place and at home, despite the attitudinal barriers they faced. Holistic intervention which takes into consideration the importance of the participant’s self-identity is vital to the successful adaptation of the participants.

5.2.4 Loss of functional abilities affected the return to work of individuals with CVA

The participants expressed that the realisation of their physical and cognitive limitations after the stroke caused functional impairments and restricted performance in work related and home context tasks. Stroke has a holistic negative impact on the post-injury RTW and the stroke survivors have to endure a range of physical, psychological, emotional and cognitive limitations, which affects the stroke survivors' ability to adapt to their worker roles. According to Burkman (2010), common deficits which occur after stroke include paralysis, loss of sensation, cognitive deficits, problems walking or speaking and difficulties with activities of daily living, such as dressing, eating, speaking and grooming. The participants were concerned with regard to their overall functioning and the effects it may have when they return to work. A key informant revealed that speech problems such as aphasia played a role in the challenge's participants experienced as some would struggle to communicate. Physical deficits often left the participants feeling frustrated as they had to adjust to their current physical status. It was noted that the participants would run out of patience when they struggled to walk and often left them with no motivation when positive results did not appear soon enough.

The stroke survivor is concerned about how they would eventually have to develop a match between their barriers and limitations of the stroke and the demands of their jobs and home contexts. They start to consider the effect of their physical, emotional, cognitive, environmental and social factors on their work ability (Radford , Grant, Terry, & Coole, 2012). During the initial stages of the program the participants struggled to cope with the basic demands of their work duties, such as book keeping, summary making, driving and cleaning. Experiencing fatigue and physical deficits such as weak grip to name a few impacted on their functional performance. Fatigue and muscle paralysis impacted on work performance by slowing down production and

work speed. As a result of this it decreased self-esteem and increased the anxiety which the participants were experiencing. Communication and language impairments negatively affected the way in which participants expressed their feelings and needs within rehabilitation. The communication difficulties negatively affecting their participation in rehabilitation as it would restrict them from gaining clarity on the instructions related to work tasks given.

5.2.5 The perception of a CVA in a rural community and the stigma related to CVA

The participants experienced stigma in their communities and were often faced with various challenges as a result of the stroke. Many of the participants were confronted with the thought of applying for a disability grant as many of their friends or family members were supportive of them doing so. The participants expressed that they found that people in the community and family members did also not understand the diagnosis and thought that the participants would never be able to return to work. This reiterates the lack of knowledge regarding stroke in rural communities. According to Urimubenshi and Rhoda (2011), a major challenge which stroke participants face is the lack of support from friends and family especially among unemployed participants. Family and friends become impatient when recovery is slow. Participants of this current study expressed that as time progressed some family and friends would encourage them more and more to apply for a disability grant as it would provide an income and the participants would never have to work. This too impacted on the participant's self-esteem and motivation in the MOOSE program.

5.2.6 Stigmatisation in the workplace due to a misconception of stroke

Based on the findings and the responses from the participants, the participants experienced social barriers within their work environments because of their stroke. As a result of the misconception regarding stroke within the participant's work and home environments they experienced social

isolation and faced attitudinal barriers. According to Maclaughlin, et al. (2004), stigma in the work place toward persons with stroke has a negative impact on work satisfaction and work reintegration. Acceptance in the workforce and home context is critical for the socialisation process which can ultimately impact work satisfaction and commitment (Mclaughlin, Bell, & Stringer, 2004). The participant's experienced that work colleagues mistrusted them and could not understand how some of the participants could return to their previous positions, such as managerial duties. According to the Social Model on disability, barriers that persons with disability face are not only physical barriers but also the attitudes found in society. Attitudes based on stereotypes and preconceptions disable people from having equal opportunities and to be a part of society. The attitudes of the participants colleagues initially prevent the participants from enjoying their engagement in occupations (Wyeth, 2012). These attitudes toward the participants left the participants feeling despondent. According to Hammel (2008) well-being is unattainable in the conditions of oppression and that there is a relationship between well-being and occupation.

5.3 Facilitators

The World Health Organisation (2016), defined facilitators as environmental factors in an individual's environment which can affect function positively if present. These facilitators include environmental factors such as, products and technology, it refers to infrastructure made to assist persons with disability to engage in occupations. Facilitators refers to positive support from the individual's relationship, attitudes and policies toward person with disability (WHO,2016).

5.3.1 Re-establishing a strong belief in functional ability through occupation

According to Wolf et al. (2014), Occupational therapy practitioners can assist clients with stroke improve their occupational performance and social participation through various intervention strategies. The strategies which the authors mention is not limited to remediation or development

of skills, compensatory strategies, activity modification and environment accommodations. The aim of the previous mentioned approaches is aiding the clients to engage in occupations, by making use of occupation-based interventions (Wolf , Chuh, Floyd, McInnis, & Williams, 2014). In line with the previous authors, Wilcock (1993), describes occupation as a way by which individuals demonstrate and use their capabilities by achievements of value and work to their society and the world.

The Model of Occupational Self Efficacy (MOOSE) facilitated the participant's independence within their homes and workplace. In the vocational rehabilitation program there was an expectation for the participants to integrate work like behaviors when they attended the sessions, such as dressing appropriately, being punctual, good work ethic and achieving productivity in the work environment. According to Soeker (2012), the MOOSE works directly on the individuals' motivation to engage in activities that improve their skills so that they are capable of being successful in the RTW process and in doing so maintaining positive work roles.

5.3.2 Rehabilitation was used as a means to improve competency through client centred activities

Person-centeredness also known as client-centeredness, is a philosophy for organizing and delivering healthcare based on patients' needs, preferences and experiences (Jesus, Bright, Kayes, & Cott, 2016). A client-centered therapy is based on what the client needs, and it is the therapists' role to promote self-understanding and independence in their rehabilitation (WHO, 2016). In Stage 1 of the MOOSE, the participants attended a session where they could express their concern regarding the rehabilitation program in which they would participate in. The session contained an information session whereby the expectations of the participants in the program was explained. This was important in order for the participants to make an informed decision whether or not the

participants wanted to participate. This gave the participants an opportunity to express their concerns and what the participants' interests were. It gave insight into what work the participant engaged in previously. It was important for the participants to feel supported and that there be a focus on the functional aspects which they wanted to focus on in the rehabilitation plan. By using a holistic approach, the occupational therapist is interested in engaging and developing the whole person in all of their life roles, activities of daily living, work and social participation to ensure the client received optimal therapy in all of their life areas and occupations (Corring & Cook, 2000).

During the stages of rehabilitation, stage two that is described by a therapeutic use of self was an important factor. The participants battled to reclaim their occupational identity and expressed being overwhelmed by the many factors of loss which impacted their previous occupations. By encouraging and being empathetic toward the participants it enhanced the motivation of participants to return to work. The aim of the MOOSE is to encourage greater self-efficacy in the participants, however as a result of the participants experiencing various emotions such as despondency and frustration, the therapist had to create a supportive environment which meets the abilities of the participants. According to Jesus et al. (2016), often client centeredness is misunderstood, it is not about giving the clients what they want or just providing information. Client-centeredness is about interacting with the client with dignity, compassion and respect. Therefore, it is important to make use of therapeutic use of self in conjunction with client-centered practice. It is about the occupational therapist seeing the participant as an individual and expert in themselves and placing the client and their family in the center of decisions (Jesus, Bright, Kayes, & Cott, 2016). The acknowledgement of the participant's fears and anxiety allowed the therapist to assess and plan individual intervention strategies for each participant. Once the participants committed to take action they were ready to start working on their goals to reclaim their

occupational identity. By continuously assessing the client's work skills the therapist could further improve the motivation and self-efficacy of the participants' in the rehabilitation program (Joy, 2010). Pierce (2003) supports the above argument where he indicates that professional optimism includes the occupational therapists' encouragement, consistent support and firm expression of belief that people can make changes in their lives often enhances the patient or client's motivation (Pierce, 2003). It could therefore be argued that in the context of the current study that the therapist facilitates the client's self- belief in themselves by means of involving them in in the process of self-reflection and engagement in real life activities (Pierce, 2003).

5.4. Relation to the Model of Occupational Self-Efficacy

5.4.1 The development of work identity through participation in the MOOSE.

This section of the chapter will specifically relate to *objective 2* of the study. Pallesen and Roenne-Smidt (2015), defined self-identity as the awareness of the qualities that distinguishes the self from others. The authors further mention that the qualities which constitutes self-identity are unique and persisting and are the basis of the experience of inner sadness and continuity. Pallesen and Roenne-Smidt (2005) indicated that one's self-identity is linked and affected by a person's thoughts and feelings about themselves.

The participants expressed that they experienced melancholy when they realised they had a stroke. The participants could no longer skilfully perform the tasks that they could before they had the stroke. In the current study the participants showed poor-judgement and reasoning when it came to setting goals for future employment. The lack of skills impacted on their self-esteem, efficacy and how the participants chose activities in which they wanted to engage in and which they previously engaged in. Pallesen and Roenne-Smidt (2005), identifies that for a stroke survivor,

because they once could perform tasks skilfully and suddenly no longer could due to the stroke, there will be a mismatch between performance and existing self-knowledge. This could in turn result in disorganisation in one's self-identity. Christiansen (2004), stated that there is a resilient connection between occupation and the individual's identity. The author elaborates and states that participation in occupation contributes to the construction of one's identity and that one builds identity through participation in occupation.

According to Walsh and Gordon (2008), an individual's work identity refers to a work-based self-concept. The authors go further to explain that an individual's work identity is only but one aspect of an individual's many personalities, yet it is the one evoked when performing vocational duties. The MOOSE according to Soeker (2012), aims to directly improve the client's motivation to engage in various activities which will improve their skills, in order for the client to be capable and achieve a successful return to work process and maintain the worker role. The rehabilitation process focused on aiding the participants in returning to work which in this study is viewed as meaningful and paid work. According to Meriano and Latella (2008), enabling people to engage in the occupation they find meaningful such as work and work-related tasks, this fulfils their human need for occupation and facilitates the process of them redefining themselves in their occupational identities (Meriano & Latella, 2008). In the current study it was illustrated that the participant was engaged in simulated work and actual work that allowed them to develop skills and competencies to allow them to have a successful reintegration into the work setting.

5.4.2. The use of the Model of Occupational Self-Efficacy as a measure to adapt to the worker role

In the section below the themes will be related to the stages of the MOOSE, this section of the chapter will specifically relate to *objective 3* of the study. There will be an emphasis on Theme

three and Theme four that links to the adaptation strategies used by individuals that was diagnosed with a stroke in a rural setting.

Stage one: A strong personal belief

According to Soeker (2012), a strong personal belief refers to the participant reflecting on their life circumstances. During the first stage of the model the participants reflected on their experiences of the stroke. At the start of this stage it was important for the Occupational Therapist to gain insight into the participant's context and to provide a holistic rehabilitation program. MOOSE encourages the participants to engage in introspection regarding their diagnosis and their experiences thereof. This enables the participants to identify possible barriers that they are aware of and in doing so find the inner strength to cope with their barriers (Soeker, 2012). In the context of the current study, during the initial stage of the stage of the model the therapist focused on building an interpersonal relationship with the participant, to gain trust and build a therapeutic relationship. In Theme one titled *Obstacles which inhibit a strong personal belief*, the participants had to come to terms with the mental, physical and emotional changes after the stroke. In this theme participants expressed the challenges they had to face on a day to day basis which in turn affected their self-esteem.

According to Keppel and Crowe (2010), the body image of stroke survivors is associated with a significant reduction in self-esteem and a reduction in their self-belief. (Keppel & Crowe, 2010). Although participants wanted to return to work, they felt that they did not understand the process of returning to work and thus felt lost. During the initial stage (Stage one) *A strong belief in functional ability the MOOSE*, education about the causes and functional deficits of the stroke and how it can affect functional performance was discussed to give the participants more insight into their diagnosis. The participants were educated on how they could overcome the functional

impairments which gave the participants a glimmer of hope in a dark situation. In Theme one; *Obstacles that inhibit a strong personal belief*, the participants faced various challenges such as loss of their functional abilities as well as the perceptions of CVA in a rural community.

With the loss of the participants functional abilities, came the fear of never returning to work or the feeling of not being capable of doing the work the participants needed to be able to provide for their families. During the initial stage of the MOOSE, the participants expressed their fears regarding stroke and it was found that it stemmed from the participants lack of knowledge regarding stroke and their prognosis. Once participants were educated on what stroke was they felt more confident and more willing to engage in a program which could help them regain their lives and fulfil their Occupational roles. Due to the participants living in a rural area and many of them being from a lower socio-economic class, many of them do not have access to the internet, as they do not have computers in their homes and their cell phones do not have internet access. As a result of this the participants could not research themselves what exactly a stroke was and went by what they were told in their community which gave an expression of a very bleak picture for the participants.

Along with the lack of knowledge and reading about their stroke and functional impairments participants also found the perception of stroke in the community challenging. Participants started seeing themselves as being “unable” or “not capable”, resulting in a decline in their self-esteem that became evident in their therapy sessions. The willingness to engage when participants were in sessions became less, as they felt they were not seeing results soon enough. Until participants fully understood what was expected of them, and what stroke was and that there was a possibility of them returning to work, only then did they take control of their lives.

It was apparent that the participants were not fully aware of the services rendered at the hospital, such as Occupational Therapy. When the participants were informed that there is a possibility that they could return to work, it changed their outlook on their future. They became more positive being aware that there was a health professional who could assist them not only with their physical impairments but that it would be a more holistic therapy including assisting them in returning to work. In doing so the relationships between the Occupational Therapist and participants grew and the participants were more open regarding their feelings about the CVA. Through expressing empathy, the participants communicated to the therapist which activities they engaged in before the stroke and how the stroke affected their functioning. Part of the activities done in this stage were having the participant looking at themselves critically. The activity involves the participant writing down words which describes who they are. Such as strong, caring and responsible. The participants then had to reflect on the aspects of themselves that changed after the stroke and identify which of these aspects they had the power to change and how they would go about changing the aspects they had control over. Based on the tasks and actions the participants could control, it made it easier for the participants to set goals for themselves and to establish what the participants wanted to achieve by the end of the program. Through open communication and regular sessions with study participants and their families, goals which are client-centered were established. According to Montagnini & Javier (2017), goal setting during rehabilitation can help maintain function and motivate client's ability to perform as the client is aware that they are working toward achieving a goal they set for themselves (Montagnini & Javier , 2017). The authors further elaborate and state that upon deciding suitable goals for rehabilitation, sustainable goals require an interaction among the client, families and the rehabilitation staff. The rehabilitation plan must also consider the patient's environment, existing functionality, and available resources

(Montagnini & Javier, 2017). The rehabilitation program that used MOOSE was very context based, it took into consideration the context of each individual participant. Therefore, the simulated tasks which were integral to the program aimed to be as close to the actual work of the participants as possible. Goal setting was part of the rehabilitation program and allowed for the participants to actively play a part in their rehabilitation and to set the goals they wanted. This was found to improve motivation and self-esteem as the participants felt that they were valued and that their opinions mattered.

The majority of the participants focused on wanting to be responsible for providing for their families and therefore returning to work was an important component they wanted to focus on. The participants indicated that due to their functional impairments they felt useless in their homes, this was very common amongst the men in the study as majority of the men were the bread winners in their homes. The participants became aware of the fact that through education their functional impairments could be improved through rehabilitation as they were attending Occupational Therapy. However, the participants were not aware that there was a possibility that they could return to work. Due the interpersonal relationship built during the rehabilitation program the participants were informed about the processes needed to return to work.

Stage two: Use of self

Stage two of the MOOSE is referred to as the participant's use of themselves as the main agents during the recovery process (Soeker,2012). Stage two of the model required that the participant take control of their recovery and to realize that they are in control regarding task initiation (Soeker,2012). During this stage the participants were given home programs to assist their functioning at home. Strengthening exercises were performed during sessions, but it was required that participants perform these exercises at home to achieve greater results. In **Theme two**, re-

establishing a strong belief in functional ability through occupation, participants progressed through the model, whereby they were expected to display the same work-related habits during sessions as they would at their actual work place. By facilitating activities which were based on the client's actual work, the participants felt more confident when they had returned to work, knowing that they would be prepared for their vocational duties. According to Ntsiea et al. (2017), stroke survivors may have recovered and have the ability to walk and use their upper limbs but might still suffer from poor endurance or speech impairments, resulting in limited ability to cope in the workplace. As a result of this factor the participants improved and progressed to feeling more confident as the necessary referrals were made for their specific impairments, such as speech therapy and physiotherapy treatment.

The therapist merely facilitated sessions but allowed for the participants to set their own goals, which gave the participants a feeling of involvement in sessions, not just feeling as though they were directed to perform activities they had no interest in. Due to the former participants starting to experience the physical and cognitive changes, they felt proud of reaching attainable goals they had set at the start and during the program. By means of including participants in sessions, goal setting and communication with employers enabled the participants to build self-confidence, which assisted the participants to progress to the stage called "A capable individual in the work place".

Activities done in the program varied as the participant's job duties varied from one another. The types of activities which were done focused on building the participants self-esteem which would be carried on through the rehabilitation process.

Examples of activities listed below:

Interpersonal skills: The participant introduced himself to three strangers in the community and started a conversation. This determined the level of the participants self-esteem and their ability to practice their interpersonal skills. The client must interact with people and ask sincere questions demonstrating concern, communicating both verbally and non-verbally in ways that demonstrate courtesy and love. The client needs to be able to listen effectively, handle difficult conversations, control his emotions and help resolve conflict. This activity was done with the participant who was a pastor.

Another one of the activities was *exploring relative distance and position*. The safe distance between pairs of people is very culture dependent as is the degree of eye contact which is permitted and certainly the amount of touch. What is explored here is the simultaneous meeting of eyes and the adjustment of distance between partners who face each other. The participants were asked to find a comfortable distance and explore their feelings and thoughts at that position, as they moved from a distance towards the comfort zone and as they went closer. This aided the Occupational Therapist as it gave the therapist an indication that the participant had spatial relation fallout. Time management activities were done asking the participants to plan a typical week and a list of duties they performed at work. They participants were also required to indicate if their duties at work had time limits. This was vital due to their decrease in work speed. Participants were required to complete pie charts on how they would perform all required vocational duties at work. Time management and stress management tips were given to participants.

Stage three: Creation of competency through occupational engagement

According to Soeker (2012), the creation of competency refers to the participant's ability to develop their self confidence in their functional skills by engaging in an occupational task. The participants engaged in simulated work tasks during the rehabilitation program. Unruh (2004)

states that “reconstructing an occupational identity may not be possible without grieving for what the client has lost or changed”. As the participants progressed they began to feel more confident in their functional abilities and the participants could come to terms with their “new” functional abilities. According to Klinger (2005), the process of adapting to ones changing of bodily and mental functioning, ultimately results in a redefinition of self-identity. In stage three of the model the participants could utilize the strategies they were taught and exposed to throughout their rehabilitation in an actual work setting. As a result of the participants being exposed to coping strategies, the participants could utilize these resources to cope with change and challenges they may face in the work environment. The participant’s motivation and self-efficacy improved during the rehabilitation program. As the participants perceived an improvement in their work skills, it encouraged their internal drive to engage in work. Through continuously practicing their work skills, the participant’s efficiency improved. This enhanced the participant’s self-confidence and in turn made the participants feel prepared and confident at work. The MOOSE model facilitated the participants to have an increased self-efficacy to the extent that the participants portrayed competency in their vocational activities and home contexts. In **Theme three** of the study, *Adaptation strategies that enhances the work participation of stroke survivors in a rural community*, the participants were able to learn and apply their knowledge regarding the adaptation strategies they were taught in stage three of the model. Under the sub category named: *Exposure to structure and income through the MOOSE program*, the participants could attend rehabilitation thoroughly knowing that they would receive compensation for their efforts. This somehow gave them a sense of calmness, as they did not have to be overly concerned about money for the program and having to provide their own lunches. Once the participants attended the sessions on a regular basis, they were able to identify opportunities where they could apply the adaptation strategies

they have learned. This was beneficial as the participants were able to apply these strategies to their simulated work tasks, which gave them a better understanding of how to apply it once they had returned to work. The participant's engaged in both physical and cognitive rehabilitation to achieve a holistic outcome. Once the participants were able to notice a change in their functioning, the participants displayed a renewed positivity during the sessions. This new-found confidence and self-belief allowed for the participants to change their perceptions with regard to returning to work. The participants did not view the return to work process as a fear anymore and they started seeing it as an opportunity to regain parts of themselves and the participants were eager to apply what they had learned at work and at home.

The process of adaptation not only took place physically and emotionally, but also with regards to reasonable accommodation, some participants needed to adapt to new worker roles. Under the sub-category; *Reintegration through reasonable accommodation in the workplace facilitates workplace adaptation*, the participants expressed contentment once they felt they could effectively perform their new adaptive roles at work. The participants expressed great gratitude, because at the start of rehabilitation their greatest concerns were being able to provide for their families, and through reasonable accommodation they are still able to work and to provide for their families. According to Schultz and Schkade (2003), occupational therapy is determined by the assumption that as clients become more functional, they will be able to adapt, however the current study indicated that as the client adapted to work related tasks then their functional skills improved. The occupational adaptation practice is based on the assumption that the more adaptive the client becomes the more functional he/she becomes. It was noted that the participants who integrated well into their worker roles and work place, were those who applied the adaptation strategies that they learnt about in the program.

Stage four: Capable individual

A capable individual refers to an individual who has engaged in meaningful occupational roles and has obtained positive feedback from the environment (Soeker, 2012). In **Theme four** of the study; *MOOSE enables transition to the worker role in a rural context*, participants were able to reflect on the work skills which they have regained or improved on during the program. At this stage the participants have returned to work and were able to give feedback on their experiences on the MOOSE program and how what was taught in the program aided them in the return to work process. The participants were able to apply the new-found adaptation strategies to actual work and it was found that the participants had experienced it to be effective. Many of the strategies were easy to do and cost effective for the participants. Such as back protection principles and work simplification principles. Once the participants had gone through the model it was found that they had regained more than just functioning, rather they regained their worker roles. They had once again become a functional member of society, they also expressed that the MOOSE assisted with functioning at their work and home contexts. It caused a ripple effect.

In impact of work in the participants lives became evident. The participants became more aware of how their impairments could affect their work and were more willing to accept reasonable accommodation. For the participants who returned to previous work duties they had applied what they had learned and found it improved their self-efficacy and motivation to perform work tasks. In instances where participants had residual effects such as fatigued during work duties, they could rely on the skills they were taught such as adjusting the task, in order for them to fit the demands of the job to their work ability. The stroke survivors' attitude toward stroke had changed, they became more accepting of their illness and realized that they needed to take control of their health. This in turn motivated the participants and their willingness to return to work. The acceptance of

their new worker identity which included the stroke condition, it gave the participants a great appreciation of their values, goals and their worker role in society.

The adaptation and modification of the work environment, home context and social context increased the participants motivation and thus improved their overall rehabilitation experience.

The participants had gone through the MOOSE program and it was found to be well suited to improve the work-related skills of the participants. Furthermore, the MOOSE allows for regress and progress, it starts with assisting the participants to adjust to their impairments before wanting to treat their impairments. The participants went through the MOOSE program and the phases of the stroke and finally returned to their worker role.



CHAPTER SIX: CONCLUSION AND RECOMMENDATIONS

6.1 Conclusion

In conclusion the focus of the study was to explore and to describe the participants experiences and their perception of the stroke (CVA) survivor's resumption of their worker role in a rural community. Four main themes developed from the study findings, namely; (1) *Obstacles which affects the return to work of CVA participants in a rural community*, (2) *Establishing a strong belief in functional ability through occupation*, (3) *Adaptation strategies that enhance the work participation of stroke survivors in a rural community* and (4) *capable individual*.

The findings of the study revealed that the participants experienced both barriers and facilitators in the rural setting. Both the barriers and facilitators were explored to gain a better understanding of the participants experiences and perceptions of returning to work once they participated in the MOOSE program. The barriers which were identified in this study, titled as; *Obstacles that affects the return to work of individuals with CVA in a rural community*, acknowledges the challenges that affected the individuals with CVA's return to work process and the adaptation into their work environments. The functional impairments which the participants experienced encompassed various factors such as the lack of knowledge regarding the return to work process and even more saw a lack of insight into the CVA and the individual prognosis thereof. Due to cognitive and emotional fallout the participant's self-esteem was impacted negatively and as a result of this it affected family and home circumstances. The impact of the CVA affected the participants roles in their daily lives which created uncertainty. Contextual hindrances were identified such as stigma regarding the CVA in the community and transport systems which affected their motivation to return to work.

Despite the several barriers which could impede the return of the participants to their worker role, facilitators were identified in the study. The facilitators that emerged were discussed in theme two *Re-establishing a strong belief in functional ability through Occupation*. The Model of Occupational Self Efficacy (MOOSE) facilitated an environment where participants were able to feel supported and enabled. Due to the model encompassing principles which addresses the participants holistically it enhanced the participants return to work probabilities. The Model allows for participants to come to terms with their losses and to come to terms with their condition. It is a model which is focused on client-centeredness and as a result of this it allows the participant to feel and be important and play an integral role in their rehabilitation process. The enhancement of work skills, the individual's coping strategies and engaging in meaningful occupations, it enhances their self-efficacy and the desire to succeed in their worker role. The MOOSE facilitates motivation for participants to regain their self-esteem and thus move forward to resume a worker role.



6.2 Limitations of the research

- Due to the context being a rural setting, it was found that three of the participants who could not return to fulfil their vocational duties due to their CVA had limited options regarding their work options. The community is small with limited employment options. Many people in the community are unemployed because of this factor. Participants felt that they would rather apply for the social grant as they knew that finding a job in the community would be difficult without a CVA, and now being compounded by their functional limitations. Three of the participants after they participated in the MOOSE Program opted to apply for a social grant.
- The study participant's first language was Afrikaans, although they are able to speak both Afrikaans and English some participants found it challenging to express themselves clearly

during the interviews. As a consequence, thereof the researcher would often resort to probing during the interview to attain clarity. Subsequently this may have resulted in the researcher leading the research participants to respond in a particular manner.

- When the participants were referred to Occupational Therapy the participants were not aware of what Occupational Therapy was. They attended sessions expecting to be treated by Physiotherapist. The participants who are more familiar with physical therapy initially did not understand the importance of attending their Occupational Therapy Rehabilitation and would often miss their appointments which resulted the researcher going out into the community to search for the participants. The education sessions with participants took longer in order to assist the participants in understanding the importance of Occupational Therapy.

6.3 Recommendations to improve the MOOSE rehabilitation programme

The researcher identified limitations of the rehabilitation programme which delayed the successful return to work process for CVA survivors in a rural community. Below are the following recommendations on how the rehabilitation program could be improved.

- The Occupational therapists should make use of materials which the clients are able to understand, most of the pamphlets which are available in the hospital are in English and written in higher level using medical terminology which the clients are unable to understand. It should be written in the participant's home language and in a manner which the participants can understand not minimising the importance of the information regarding the CVA.
- It is recommended that the Occupational Therapist does more Occupational Therapy awareness campaigns in the community as well as what Occupational Therapy services are offered at the hospital. This can be done by doing talks at surrounding clinics in the community, radio talks

as well as information sessions with South African Social Security Act (SASSA) and other medical referring sources.

- Once participants and clients have completed the rehabilitation programme and are discharged. The Occupational Therapist should ensure that there is a support structure for the participants such as providing the participants with contact numbers of other CVA survivors in cases where they feel stressed. This can however only be done with the permission of the participants. The participants should also be given information with regards to work related questions and a social worker they could contact when they have social related concerns.
- Participants should be followed up for 6 months after they have returned to work to ensure that the participants are making use of the strategies they were equipped with in the rehabilitation programme. This will also allow the Occupational Therapist to meet with the employer to discuss any issues related to the participant.
- To enhance the return to work process of individuals with CVA, the Occupational Therapist should do education sessions with employers and employees regarding the CVA survivor's capabilities, this will assist in the reduction of the work place employees and employers' uncertainties regarding work performance.
- It is recommended that the Occupational Therapist contacts the employer early during the rehabilitation process as this will allow the employer to enquire regarding the participants capabilities and allow the employer to adjust any duties for the participant well in advance. This also allows the participant to feel a sense of security as they are not the only ones in contact with the employer and that they feel they have a health professional that can advocate for them.

- It is recommended that a health promotion program which focuses on stroke prevention be put into place. The risk factors regarding stroke should be made aware to the community. The community members who have had strokes and now have residual functional abilities as a result should be made aware of their return to work rights. Misconceptions regarding stroke should be addressed not only by the Department of Health but also other organisations, such as Social Development, non-governmental organisations and disability rights groups to address the stigma regarding stroke and aim to eradicate it. This can be done by means of talks in the community, the local newspaper, posters and radio talks.

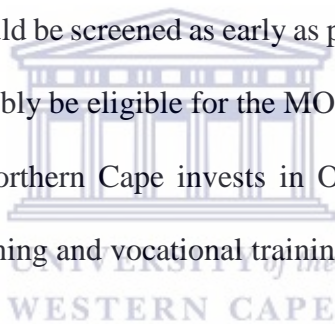
6.4 Recommendation for future occupational therapy research

- It is suggested that similar studies be done in rural areas as these studies will give Occupational Therapists a broader understanding on the return to work process of a stroke survivor in a rural community and the challenges that come with it. Further research will allow for Occupational Therapists to assist each other with information on how to proceed with vocational placement in a rural community and the different challenges clients in a rural community face daily.
- It is recommended that a longitudinal study conducted over a period of two years in order to monitor whether or not participants are able to adapt to their work places and how they are able to do so. It will also allow Occupational Therapist to identify and investigate the reasons behind participants who choose to leave after a couple of years if they choose to do so. This can help identify factors which lead to absconding from work and address these issues in rehabilitation programmes.

- A survey should be conducted in rural communities regarding the usefulness of the occupational therapy services in improving work related skills of stroke survivors. The survey should also enquire about suggestions for the improvement of those services.

6.5 Recommendation for Policy development

- The Occupational Therapist should be in close contact with the South African Social Security Agency (SASSA) Doctor, while the participants are engaged and attending the MOOSE program. It is suggested that the participants are supported financially with a temporary grant in order to support them financially while completing rehabilitation.
- All individuals with stroke should be screened as early as possible after their diagnosis in order to determine if they could possibly be eligible for the MOOSE program
- It is recommended that the Northern Cape invests in Occupational Therapists to do work assessments, prevocational training and vocational training.



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APPENDIX A: RESEARCH INFORMATION SHEET



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INFORMATION SHEET

Project Title: The experiences and perceptions of individuals with stroke about the usefulness of the Model of Occupational Self Efficacy in a rural setting.

What is this study about?

This is a research project being conducted by a post graduate Occupational Therapist at the University of the Western Cape. I am inviting you to participate in this research project because you have participated in a supported employment programme, specifically the Model of Occupational Self-Efficacy. The purpose of this research project is to explore the experiences and perceptions of individuals, with a diagnosis of CVA, returning to work after having participated in the model of Occupational Self Efficacy programme.

What will I be asked to do if I agree to participate?

You will be asked to take part in an interview at Abraham Esau Hospital or at your workplace. This interview will be 45 to 60 minutes long and will take place at a time mutually convenient to you. In the interview you will be asked questions about the Model of Occupational Self efficacy employment programme and how it influenced your return back into the workplace.

Would my participation in this study be kept confidential?

The researchers undertake to protect your identity and the nature of your contribution. To ensure your anonymity your name will not be included on the collected data and a pseudonym will be used instead.

This research project involves making audiotapes of you, allowing the researcher to gather the data as accurately as possible. To ensure your confidentiality, the voice recordings and transcriptions of the findings gathered in the interviews will be locked away in a cupboard, and only be accessed by the researcher. Once the study is completed the voice recordings will be deleted.

- I agree to be audiotaped during my participation in this study.
- I do not agree to be audiotaped during my participation in this study.

If we write a report or article about this research project, your identity will be protected.

What are the risks of this research?

There may be some risks from participating in this research study. All human interactions and talking about self or past emotional situations carry some amount of risks. We will nevertheless minimise such risks and act promptly to assist you if you experience any discomfort, psychological or otherwise during the process of your participation in this study. Where necessary, an appropriate referral will be made to a suitable professional for further assistance or intervention or you will be provided with information of services which will provide further support.

What are the benefits of this research?

This research is not designed to help you personally, but the results may help the researcher learn more about the programmes used, and the effectiveness thereof, which guide individuals with stroke back into the workplace. We hope that, in the future, other people might benefit from this study.

Do I have to be in this research and may I stop participating at any time?

Your participation in this research is completely voluntary. You may choose not to partake in it. If you decide to participate in this research, you may withdraw from the study at any given time. If you decide not to participate in this study or if you withdraw from the study, you will not be penalized or lose any benefits to which you otherwise qualify. If your job at the facility which you are currently working is terminated before the interview has taken place, your participation within the study will be terminated, as you will no longer fall within the inclusion criteria.

What if I have questions?

This research is being conducted by Melissa Smith, Occupational Therapy Master's student at the University of the Western Cape. If you have any questions about the research study itself, please contact Melissa Smith: 082 8690522, email: 3151026@myuwc.ac.za or melissa4smith@gmail.com

Should you have any questions regarding this study and your rights as a research participant or if you wish to report any problems you have experienced related to the study, please contact:

Head of Department:

Prof. MS Soeker
University of the Western Cape
Private Bag X17
Bellville 7535
(021) 959 9339
msoeker@uwc.ac.za



Dean of the Faculty of Community and Health Sciences:

Prof José Frantz
University of the Western Cape
Private Bag X17
Bellville 7535
chs-deansoffice@uwc.ac.za

This research has been approved by the University of the Western Cape's Senate Research Committee. (REFERENCE NUMBER: - 130416-049)



APPENDIX B: CONSENT TO CONDUCT STUDY AT CALVINIA PHC



UNIVERSITY OF THE WESTERN CAPE

Private Bag X 17, Bellville 7535, South Africa

Tel: +27 21-959 9339, Fax: 27 21-959 9359

E-mail: msoeker@uwc.ac.za

Permission Letter

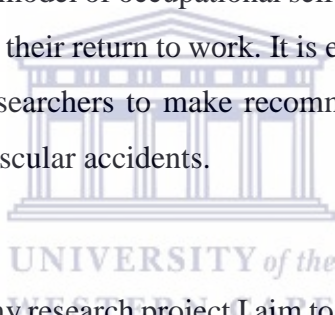
The Northern Cape Department of Health

Dear: Sir/Madam

REQUEST FOR PERMISSION TO CONDUCT A RESEARCH STUDY AT CALVINIA PRIMARY HEALTHCARE CENTRE

As part of the postgraduate Occupational Therapy (MSc. OT) course at the University of the Western Cape (UWC), I am required to conduct a research study. I wish to obtain permission to conduct research with the rehabilitation experts at Calvinia Primary Health Care Centre.

The aim of the study is to adapt the model of occupational self-efficacy for application with clients who have experienced stroke to aid their return to work. It is envisaged that the knowledge gained from this study would help the researchers to make recommendations to rehabilitation experts working in the field of Cerebral Vascular accidents.



In order to gain sufficient data for my research project I aim to conduct a semi-structured interview and focus groups for approximately 30-35 minutes at the hospital. The clients that will be seen are Occupational Therapy clients and the time taken to do the interviews and groups will not disadvantage the clients at the hospital. Appropriate time will be allocated to do the research. The topic being covered in the research is within my scope of practice. The research is

beneficial to the community and the hospital as it will give the therapist an opportunity to expand my knowledge base, and in turn to offer treatment to the clients which is an advantage.

Please find my research proposal attached for a more detailed account of my research topic, the research process and the ethics related to this research project. I will be pleased if permission is granted to me, as I look forward to conducting this research project.

If you require any further information regarding this request you are welcome to contact my research supervisor:

Name: Dr. Shaheed Soeker

Department: Occupational therapy

Contact: 021 959 9339

Email: msoeker@uwc.ac.za

Kind regards

Melissa Smith

MSc (Occupational Therapy Student)

Cell: 082 8690522



UNIVERSITY of the
WESTERN CAPE

Permission Granted :

Date Signed :

Permission Denied :

Date Signed:

APPENDIX C: CONSENT TO CONDUCT STUDY AT ABRAHAM ESAU HOSPITAL



UNIVERSITY OF THE WESTERN CAPE

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UNIVERSITY of the
WESTERN CAPE
E-mail: msoeker@uwc.ac.za

Permission Letter

The Northern Cape Department of Health

Dear: Sir/Madam

REQUEST FOR PERMISSION TO CONDUCT A RESEARCH STUDY AT ABRAHAM ESAU HOSPITAL

As part of the postgraduate Occupational Therapy (MSc. OT) course at the University of the Western Cape (UWC), I am required to conduct a research study. I wish to obtain permission to conduct research with the rehabilitation experts at Abraham Esau Hospital.

The aim of the study is to adapt the model of occupational self-efficacy for application with clients who have experienced stroke to aid their return to work. It is envisaged that the knowledge gained from this study would help the researchers to make recommendations to rehabilitation experts working in the field of Cerebral Vascular accidents.

In order to gain sufficient data for my research project I aim to conduct a semi-structured interview and focus groups for approximately 30-35 minutes at the hospital. The clients that will be seen are Occupational Therapy clients and the time taken to do the interviews and groups will not disadvantage the clients at the hospital. Appropriate time will be allocated to do the research. The topic being covered in the research is within my scope of practice. The research is beneficial to the community and the hospital as it will give the therapist an opportunity to expand my knowledge base, and in turn to offer treatment to the clients which is an advantage.

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If you require any further information regarding this request you are welcome to contact my research supervisor:

Name: Dr. Shaheed Soeker

Department: Occupational therapy

Contact: 021 959 9339

Email: msoeker@uwc.ac.za

Kind regards

Melissa Smith

MSc (Occupational Therapy Student)

Cell: 082 8690522

Permission Granted :

Date Signed :

Permission Denied :

Date Signed:



APPENDIX D: INDIVIDUAL CONSENT FORM



UNIVERSITY OF THE WESTERN CAPE
Private Bag X 17, Bellville 7535, South Africa
Tel: +27 21-959 9339, Fax: 27 21-959 9359
E-mail: msoeker@uwc.ac.za

CONSENT FORM

Title of Research Project: The experiences and perceptions of individuals with stroke about the usefulness of the Model of Occupational Self Efficacy in a rural setting

The study has been described to me in language that I understand. My questions regarding the study have been answered. I understand what my involvement will entail, and I agree that my participation is my own choice and free will. I understand that my identity will not be disclosed to anyone. I understand that I may withdraw from the study at any time without reason and without fear of negative consequences or loss of benefits.

Participant's name:

Participant's signature:

Date:

Appendix E: Interview Guide

1. Could you describe how you felt about your health condition and the way your stroke impacted on your life, before you started the programme?

Probe: What activities did you participate in with regards to work that you thought you would not be able to do again?

Probe: What feelings did you experience?

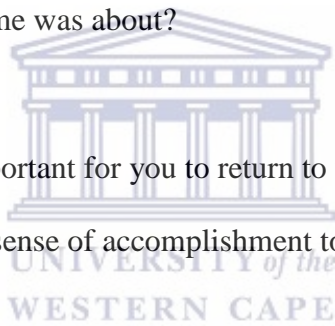
2. Could you describe the programmes you participated in that assisted you in returning to work?

Probe: Describe your feelings towards the programme?

Probe: Describe what the programme was about?

3. Could you describe why it was important for you to return to work?

Probe: Do you feel that it brings a sense of accomplishment to your life?



4. Could you describe how the programme assisted you in returning to work?

Probe: Would you say, you had an input in choosing which activities you could do in the programme, which would help to develop work skills?

Probe: Were you able to focus on areas which you felt needed attention, such as improving your lack of concentration or improving grip strength?

5. Could you describe any new worker skills you have developed in the programme?

6. Could you describe challenges you have faced in returning to work?

Probe: Which aspects of the programme did you find most challenging?

Probe: Do you feel that co-workers perceive you differently?

7. Could you describe the challenges you have found returning to work in a smaller community?
8. What would you recommend to be changed in the rehabilitation programme?

Probe: Which part of the programme did you find assisted you the most to return to work?

Probe: Which part of the programme for you feel, you did not understand or did not find helpful?



APPENDIX F: FOCUS GROUP CONSENT FORM



UNIVERSITY OF THE WESTERN CAPE
Private Bag X 17, Bellville 7535, South Africa

Tel: +27 21-959 9339, Fax: 27 21-959 9359

E-mail: msoeker@uwc.ac.za

FOCUS GROUP CONFIDENTIALITY BINDING FORM

Title of Research Project: The experiences and perceptions of individuals with stroke about the usefulness of the Model of Occupational Self Efficacy in a rural setting

The study has been described to me in language that I understand. My questions about the study have been answered. I understand what my participation will involve and I agree to participate of my own choice and free will. I understand that my identity will not be disclosed to anyone. I understand that I may withdraw from the study at any time without giving a reason and without fear of negative consequences or loss of benefits. I understand that confidentiality is dependent on participants' in the Focus Group maintaining confidentiality. I hereby agree to the following:

I agree to uphold the confidentiality of the discussions in the focus group by not disclosing the identity of other participants or any aspects of their contributions to members outside of the group.

Participant's name.....

Participant's signature.....

Date.....



UNIVERSITY *of the*
WESTERN CAPE

Appendix G: Focus Group Interview Guide

1) Could you describe how the rehabilitation programme has facilitated your return to work process?

Probe: What kind of support did you receive?

Probe: Did the therapist assist with regards to speaking to employers?

Probe: Do you feel that there was a partnership between therapist and client, with regards to decisions?

2) Could you describe the challenges faced once you returned to work?

Probe: Did you experience a change in co-workers attitudes toward you?

3) Could you describe the barriers relating to the rehabilitation programme you participated in?

Probe: How did you achieve your goals in these programmes?

4) Could you describe changes in your life because of your participation in the rehabilitation programme?

Probe: How has returning to work affected your wellbeing?

5) Could you describe which aspects of the program you made use of?

Probe: Physical or cognitive exercises?

Probe: Did you make use of work simplification energy conservation techniques?

6) Would you recommend this programme to other clients?

APPENDIX H



OFFICE OF THE DIRECTOR: RESEARCH RESEARCH AND INNOVATION DIVISION

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01 November 2016

Ms MP Smith
Occupational Therapy
Faculty of CHS

Ethics Reference Number: HS/16/6/16

Project Title: The experiences and perceptions of individuals with stroke about the usefulness of the Model of Occupational Self Efficacy in a rural setting.

Approval Period: 31 October 2016 – 31 October 2017

I hereby certify that the Humanities and Social Science Research Ethics Committee of the University of the Western Cape approved the methodology and ethics of the above mentioned research project.

Any amendments, extension or other modifications to the protocol must be submitted to the Ethics Committee for approval. Please remember to submit a progress report in good time for annual renewal.

The Committee must be informed of any serious adverse event and/or termination of the study.

A handwritten signature in black ink that reads 'Josias'.

*Ms Patricia Josias
Research Ethics Committee Officer
University of the Western Cape*

PROVISIONAL REC NUMBER - 130416-049

APPENDIX I



Digital Receipt

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