UNIVERSITY of the
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THE RELATIONSHIP BETWEEN SPIRITUALITY, HEALTH-RELATED QUALITY OF LIFE AND OCCUPATIONAL BALANCE AMONG ADULTS WITH CHRONIC DISEASES

Yasmeen Parker

(Student number: 2212852)

A thesis submitted in fulfilment of the requirements for the degree of Masters Science in the Occupational Therapy, Department of Occupational Therapy, Faculty of Community and Health Sciences, University of the Western Cape

Supervisor:

Dr Thuli G. Mthembu

Co-supervisor:

Dr Lucia Hess-April

DECLARATION

I, Yasmeen Parker hereby declare that "**the relationship between spirituality, health-related quality of life and occupational balance among adults with chronic disease"**, is my own work and that it has not been submitted before for any degree or examination in any other university, and that all the sources I have used or quoted have been indicated and acknowledged as complete references.

Yasmeen Parker

Name Date

Signed …….

Abstract

Background: One of the most significant current discussions in public health and occupational therapy is the challenges facing adults with chronic diseases. Adults living with chronic diseases experience challenges of activity limitations and occupational disruptions which may influence their health, quality of life and well-being. Chronic diseases seem to have implications for adults' areas of occupation, client factors and performance patterns as well as performance skills. Spirituality is considered as important in the lives of adults living with chronic diseases as a coping strategy assisting them to deal with the challenges of life in relation to physical, social, emotional and functional well-being. Despite the importance of spirituality in adults with chronic diseases, there is little known about the relationship between spirituality, health-related quality of life and occupational balance among adults with chronic diseases in the Western Cape, South Africa.

Aim: The aim of the study was to examine the relationship between spirituality, health-related quality of life and occupational balance from the perspectives of adults living with chronic diseases.

Methods: A sequential exploratory mixed methods two phase design approach was used for the purpose of the study. Thus, to examine the perspectives and determine the relationship on spirituality, health related quality of life and occupational balance of adults living with chronic diseases. Furthermore, to explore and describe the perceptions of adults with chronic diseases regarding the relationship between spirituality, health related quality of life and occupational balance.

Phase one: The study used a mixed methods approach with a quantitative research design approach with a cross-sectional correlation research design. A self-administered fourfold questionnaire was used for data collection: Part A: socio-demographics, Part B: Occupational

Balance-Questionnaire, Part C: Functional Assessment of Chronic Illness Therapy-Spiritual Well-Being (FACIT-Sp-12), and Part D: Spiritual Needs Questionnaire (SpNQ). All analysis was conducted by means of the Statistical Package for the Social Sciences (SPSS) for descriptive and inferential statistics.

Phase two: An exploratory-descriptive qualitative research design was utilised to gain the perspectives of adults with chronic diseases. Three focus groups discussions were held with 7 participants. Thematic analysis was used to analyse the focus group discussions to obtain and identify codes, which were then placed in categories and themes. Trustworthiness was ensured through triangulation of data sources and data collection methods, member checking, detailed description, an audit trail and reflexivity. The researcher ensured that the ethics procedures upheld the principles of autonomy, beneficence, non-maleficence, justice and veracity.

Results: In **phase one**: all the participants were adults living with chronic diseases and residing within the Delft community. The study findings presented that 94.8% of participants' reported that they are part of a religion in relation to their spiritual and religious beliefs. In addition, 0ne hundred and nine participants (37.2%) considered themselves to be both spiritual and religious where as 25.9%, participants (n=108) considered themselves as spiritual only. God has a significant impact on the adults living with chronic diseases. Thus, turning to a higher presence participants (69.6%) seemed to be in strong agreement. Furthermore, result findings indicate that 60.8% of adults living with chronic diseases were in agreement with the importance that someone prays for them and 57.2% reported very strong in agreement to pray with someone. In relation to the relationship between spirituality and health related quality of life emerged from theme one 'Trying to live healthy by accepting my chronic illness' suggests that the notion of acceptance as well as insight into understanding of adults living with chronic illness holds fundamental importance in their

coping and self-management. These factors may explain the relatively good correlation between spiritual needs to find meaning in illness and/or suffering and health related quality of life of the quantitative phase of this study: physical well-being, I feel ill (.173**); emotional well-being, I worry about dying (.140*) and additional concerns my life has been productive (.167*), I have a sense of purpose in my life (0.165*), I am able to reach deep down into myself for comfort (.162*), I have a sense of harmony within myself(0.181**), I find comfort in my faith and spiritual belief (.186**), I find strength in my faith or spiritual beliefs (0.160*) and my illness has strengthened my faith or spiritual beliefs (.227**). In this study, relationships were found between emotional well-being and religious spiritual needs coping (r=.224**); functional well-being and spiritual needs it was found that there was an association with enjoying the things they used to do for fun (r= .219**) as well as being content with the quality of their life (r=.199**). Furthermore, relationships were found between actively giving of spiritual needs and social/family well-being of health related quality of life among adults living with chronic illness. The results indicated that there were a relationship between feeling close to their friends (r=.127*), their life has been productive (r=209**) and feeling a sense of purpose in their life (r=.322**) amongst adults living with chronic illness. In addition, the findings between spiritual needs and occupational balance, it was found that there were relationships between spiritual needs and having a variety of activities. Engaging in occupations, such as someone from the religious community care for adults living with chronic illness (-.163*). Furthermore, praying with someone (-.148*), to participate in religious ceremonies (.218**), and to pass on your life experiences (-.141*).

Phase two: three themes emerged from the thematic analysis of the data to explain the relationship between spirituality, and health related quality of life and occupational balance: 'Trying to live healthy by accepting my chronic illness'; 'The things we used to do are now challenging'; and 'Spiritual experiences through the journey of life'.

Conclusion and recommendations: overall, the findings of the study demonstrated that there is a relationship between spirituality, health related quality of life and occupational balance among adults living with chronic illness. This is further explained by the three themes that emerged in phase two that adults living with chronic diseases manage to live healthy through acceptance and understanding of their illness. Despite the challenges faced by the adults living with chronic diseases they manage to share their spiritual experiences through their personal journey. Thus, it is recommended that occupational therapy continuing professional training should provide opportunities for integrating spirituality in occupational therapy practice, policies and education.

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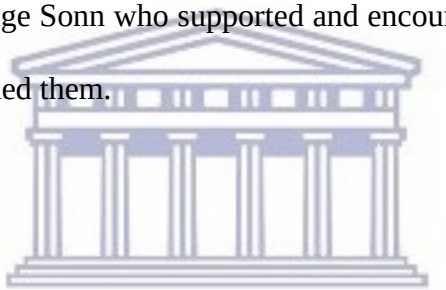

ABBREVIATIONS AND ACCRONYMNS

AOTA: American Occupational Therapy Association

BADL: Basic Activities of Living

CHC: Community Health Centre

COMP-E: Canadian Model of Performance and Engagement

COPD: Chronic Obstructive Pulmonary disease

Facit-sp-12: Functional Assessment of Chronic Illness

FGDs: Focus Group Discussions

HR QOL: Health-Related Quality of Life

IADL: Instrumental Activities of Daily living

MS: Multiple Sclerosis

NCD: Non –Communicable Diseases

OB-Quest: Occupational Balance

PHC: Primary Health Care

QOL: Quality of Life

SA: South African

SpNQ: Spiritual Needs Questionnaire

SPSS: Statistical Package for the Social Sciences

WHO: World Health Organization

KEYWORDS

Adults

Chronic Diseases

Health-Related Quality of life

Occupational Balance

Spirituality

Definitions

Spirituality: "Is rooted in an awareness which is part of the biological make-up of the human species. Spirituality is potentially present in all individuals and it may manifest as inner peace and strength derived from a perceived relationship with a transcendent God/an ultimate reality, or whatever an individual values as supreme" (Narayanasamy, 1999).

Spirituality: "A dynamic and intrinsic aspect of humanity through which persons seek ultimate meaning, purpose and transcendence, and experience relationships with self, family, others, community, society, nature, and the significant or sacred. Spirituality is expressed through beliefs, values, traditions and practices" (Puchalski et al., 2014, p. 646).

Spiritually competent occupational therapy practice: "Spiritually competent occupational therapy practice engages a person, as a unique spiritual being, in occupations which will provide them with a sense of meaning and purpose. It seeks to connect or reconnect them with a community where they experience a sense of wellbeing, addresses suffering and develops coping strategies to improve their quality of life. This includes the occupational therapist accepting a person's beliefs and values whether they are religious in foundation or not and practicing with cultural competency" Jones (2017).

Spiritual care: Is defined as activities and ways of being that bring spiritual quality of life, well-being and function, all of which are dimensions of health, to clients" (Taylor, 2002, p. 24).

Chronic diseases: "Are a long lasting group of diseases that share similar risk factors because of exposure, over many decades, to unhealthy diets, smoking, lack of exercise, and possibly stress (Steyn, Fourie & Temple, 2006). These chronic diseases include heart disease,

stroke, cancer, chronic respiratory diseases, mental disorders, oral diseases and genetic disorders" (Megari, 2013).

Occupations: "Occupations" refer to goal-directed, meaning- and purposeful everyday activities that people do as individuals and in their social contexts" (Dür et. al, 2014).

Occupational balance: "Is defined as to be involved in different kinds of occupations in a self-motivated way so that the individual has a combination of occupations that leads to health and to high quality of life as experienced by the individual" (Stamm. et al, 2007; Wagman, 2012).

Occupational engagement: "Comprises of what people do, where and with whom they spend their time, and the perceived level of competence and meaningfulness of their time use" (Nilsson.et.al, 2013).

Quality of life: "May be defined as a comparative state of well-being and functioning which includes a level of comfort and an ability to participate in meaningful tasks or activities" (Spear & Crepeau, 2003).

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CHAPTER ONE

INTRODUCTION

1 Chapter overview

In this chapter, a background to the study, chronic diseases and spirituality, chronic diseases and occupational balance, statement of the problem and research questions are described. In addition, the aim, objectives, significance and outline of the study are presented.

1.1 Background to the study

One of the most significant current discussions in public health and occupational therapy is the challenges facing adults with chronic diseases (Adegbola, 2006; Zeighami, Tajvidi & Ghazizadeh, 2014). Chronic diseases are a long lasting group of diseases that share similar risk factors because of exposure, over many decades, to unhealthy diets, smoking, lack of exercise, and possibly stress (Steyn, Fourie & Temple, 2006). These chronic diseases include heart disease, stroke, cancer, chronic respiratory diseases, mental disorder, oral diseases and genetic disorders. Chronic diseases have implications for adults' areas of occupation, client factors and performance patterns as well as performance skills (Law, Steinwender & Leclair, 1998).

Previous studies have reported that adults with chronic diseases experience activity limitations and occupational disruptions in basic activities of daily living (BADL), instrumental activities of daily living (IADL), leisure, work, and social participation (McDonald, Dietrich, Townsend, Cox & Backman, 2012; Levine & Targ, 2002; Sawyer & Aroni, 2005; Adegbola, 2006; Zeighami et al., 2014). Additionally, progression of chronic diseases overtime is associated with activity limitation to perform basic activities of daily

living (BADLs), such as bathing, eating, and getting in and out of bed (Hand, Law & McColl, 2011; Ralph, Mielenz, Parton, Flatley, & Thorpe, 2013).

Several studies indicated that chronic diseases' treatment regimens are complex to manage due to the demands that influence clients and their families. Therefore, chronic diseases affect adults' family function, appearance, identity, mental health, sibling and marital relationships, as well as physical, psychological and social aspects of quality of life. A study aimed to determine the impact of eight chronic diseases on health-related quality of life (HRQOL) of Chinese patients confirmed that chronic diseases have adverse effects on patients' life (Lam & Lauder, 2000; Sirilla & Overcash 2012). HRQOL is viewed as a person's awareness of health-related subjective experiences, psychosocial, daily role, physical, social functioning, well-being and general health perception (Lam & Lauder, 2000; Megari, 2013).

The South African (SA) healthcare system faces an increase in the burden of disease, characterised by HIV/AIDS and TB, injury and violence, maternal and child health issues, and NCDs. In the Western Cape, NCDs make up five of the ten leading causes of death: ischaemic heart disease, diabetes, cerebrovascular disease, lung cancer and COPD (Lalkhen & Mash, 2015). A recent study done by Lalkhen and Mash (2015) reflected that NCDs are estimated to contribute 28% to the total burden of disease, and is anticipated to increase substantially over the next few decades if measures are not taken to fight the inclination. The study took place within the primary health care facilities PHC in South Africa in the Western Cape, North West, Northern Cape and Limpopo provinces to evaluate the multi-morbidity amongst patients with non-communicable diseases. The results reflected that about half of the patients with NCDs had a comorbidity, and multi-morbidity was common in patients with COPD and osteoarthritis. The study furthermore discussed that comorbidity in patients with

NCDs ranged from 65.2% of persons diagnosed with diabetes to 24,5% diagnosed with epilepsy, and hypertension was the commonest comorbid condition. Multi-morbidity on the other hand was found in 14.4% of individuals changing to 36.4% in persons with COPD to and 6.7% in those with epilepsy. Lalkhen and Mash (2015) expressed that family physicians may provide more patient-centered care and by using a biopsychosocial approach as a result of their generalist training. Additionally, the researcher emphasize that family medicine looks at the person holistically which includes the person's family, environment, social cultural and psychological circumstances, and highlights the fact that spirituality is an often neglected factor in the healthcare of patients. Thus, spirituality is identified as an important, multidimensional aspect of the human experience that is difficult to fully understand or measure using the scientific method, yet substantial evidence in the medical literature supports its valuable role in the practice of medicine (Pulchalski et al., 2014; Rajah & Hight, 2001).

Spirituality tends to add to the healing and recovery of individuals suffering from different conditions such as HIV, cardiac, mental health issues and other chronic conditions. Mthembu, Ahmed, Nkuna and Yaca (2014) established that spirituality was linked with experiences of social support. In a qualitative study, Mthembu et al, (2014) found that spirituality or link with God offered women an opportunity to give meaning and take perspective so that they have a source of support, a sense of control provided through a more powerful being and offer a path to the community. For example, Mthembu et al.'s (2014) study highlights that the basis of support for the women that participated in his study, was expressed as communication with a supportive friend and engagement in spiritual practices such as daily prayer and meditation to calm stress and revitalize their mood. Similarly, Sessanna et al. (2007) underline

spirituality as a journey to find meaning and purpose, as self-transcending knowledge, meaningful relationships, love, commitment, as well as a sense of holiness among people.

1.2 Chronic diseases and spirituality

People living with chronic diseases often find themselves searching within their inner self as well as their environment in order to find ways to improve their physical wellbeing and quality of life. Thus, previous studies have reported that adults with chronic diseases tend to use spirituality as a coping strategy to deal with the challenges of life (Levine & Targ, 2002; Adegbola, 2006; Mthembu, et al., 2014; Zeighami, et al, 2014; Mthembu, Abdurahman, Ferus, Langenhoven, Sablay, & Sonday, 2015). Additionally, Mayers and Johnston (2008) confirmed that the benefits of spirituality/religion to health and well-being are threefold: 1) prevention, 2) quick recovery and 3) fostering composure in the face of ill health. According to Puchalski (2014, p.644), "spirituality is the dynamic dimension of human life that relates to the way persons (individual and community) experience, express and/or seek meaning, purpose and transcendence; and the way they connect to the moment, to self, to others, to nature, to the significant, and/or the sacred. Spirituality is considered as a core of, and integral to quality of life and need to be accessible for all people in a way that is meaningful to their beliefs, culture and context".

Moreover, spirituality evokes feelings, which show the existence of love, faith, hope, trust, awe, and inspirations; therein providing meaning and a reason for existence (Narayanasamya, Clissett, Parumall, Thompson, Annasamy & Edge, 2004). Similarly, it is highlighted that spiritual activities such as belief in a deity, prayer and meditation seem to improve human health and well-being (Neil Scheurich, 2003). Furthermore, spiritual needs are the needs as well as the expectations through which people find meaning and purpose as well as value in their life. These needs could be religious but for those who have no religious faith or do not

belong to an organized religious belief system these needs generally provide meaning and purpose to their lives (Murray, Kendall, & Boyd, 2004).

Research has shown that a large number of adults with chronic diseases are engaging in spiritual occupations such as belief in a deity, prayer and meditation to enhance their health and well-being (Scheurich, 2003; Kang, 2003). Furthermore, spiritual occupations were reported to be providing meaning, purpose, as well as value in life. Several studies have focussed only on stress, but there has been no factual research on the relationship of religious, spiritual or lifestyle behaviours with regards to the well-being of adults living with chronic illness (Sulmasy, 2002). Additionally, research has shown that the adult living with chronic diseases consider social participation as one of the occupations that is associated with quality of life and well-being (Bennett, 2005; Levasseur, Desrosiers & St-cyr Tribble, 2008).

Providing support to adults living with chronic diseases can be a challenging occupation to parents, family and health professionals, including occupational therapists alike (Mthembu, Brown, Cupido, Razack & Wassung, 2016; Restall, Ripat & Stern, 2003; Sawyer & Aroni, 2005). Moreover, Turcotte, Carrier, Desrosiers and Levasseur (2015) suggest that occupational therapists need to use health promotion through collaborations with other stakeholders. These collaborations may assist adults with chronic diseases through effective coping skills, adapting task methods, and creating supportive environments for meaningful and purposeful occupations (Townsend & Polatajko, 2013). Given the fact that occupational therapists have to provide services to adults with chronic diseases, it can pose a challenge as communities are multi-cultural, multi-religious and spiritually diversified (Janse Van Rensburg, Poggenpoel, Szabo, & Myburgh 2014). For instance, the population of South Africa has a wide variety of cultures, religions and spiritual beliefs. Therefore, occupational therapists need to work alongside diversified populations to promote holistic healthcare to adults with chronic diseases.

1.3 Chronic disease and occupational balance

Living with chronic illness may find many individuals facing challenges in engaging in meaningful occupations and striking a balance. According to a study done by Dür et al. (2014) "occupations" refer to goal-directed, meaning- and purposeful everyday activities that people do as individuals and in their social contexts. In addition, occupational therapists focus on occupations as a means, but also as an outcome of occupational therapy intervention. In addition, Nilsson (2006) refers to occupation as the term used to refer to doing that has meaning and purpose to the doer. However, activity is used to describe the doing but has no importance on meaning or purpose, while a task is used to refer to what is or was done. Furthermore, engagement in occupation has long been considered as an important process for achieving a healthy life (Nilsson, 2006). Thus as occupational therapists theoretical base relates to the knowledge that good health comes through engagement in occupation and the traditional belief that health can be enriched by occupation (Nilsson,2006). This is consistent with Hammell's view that "occupations are meaningful to people when they fulfil a goal or purpose that is personally or culturally important" (Hammell, 2004, p.297). Thus, this implies that occupations are meaningful and denotes that it is a positive term that has some meaning for the individual engaged in them (Hammell, 2004). Hence, occupational engagement comprises of what people do, where they do it and with whom they spend their time, and the perceived level of competence and meaningfulness of their time used (Nilsson, Blanchard, & Wicks, 2013). One of the main concerns for persons experiencing an illness or injury is the interruption of doing and the ability to engage in personally meaningful occupations, thus impairments is experienced both physiologically and occupationally. Together with a supportive social system, the right material resources, and forms of lifestyle an individual can empower change from an image of a disabled self to one of a capable self.

In relation to this process of change towards a capable self, Hammell (2004) suggests that many people who have physical impairments go through a conceptual transformation to an extent that they change the way they perceive disability. By means of focusing on their abilities and accomplishments and choosing to decrease their losses, they see themselves as competent and capable to engage in occupations (Hammell, 2004).

Occupational balance is another important concept that links occupation and health from the perspectives of occupational therapists (Dür et al., 2014). According to Dür et.al (2014), occupational balance refers to balance between different occupational areas, such as work, play rest and sleep. Thus, occupational balance is defined as being involved in different kinds of occupations in a self-motivated way so that the individual has a combination of occupations that leads to health and to high quality of life, while occupational imbalance is defined as the interference in occupation and viewed as a cause for ill health (Stamm, Lovelock, Stew, Nell, Smolen, Machold, Jonsson & Sadlo, 2009; Wagman, 2012). However, Stamm et al. (2009) found that a balance of work and life is needed between challenging versus relaxing occupations and between activities that are meaningful for the individual in a sociocultural context. In addition, occupational balance does not necessarily require being engaged in paid work but rather extends paid work to challenging activities and any kind of productive activities (Stamm.et al., 2009; Backman, 2004).

While definitions are primarily obtained from the viewpoints of occupational therapists, the perspectives of patients and healthy people are rare to be found in literature (Dür et al., 2014). Moreover, it cannot be assumed that it should be healthy for all individuals to have a balance between work and life, preferably when considering other aspects such as challenges in activities or meaningfulness from an individual and a societal viewpoint. Furthermore, Stamm et al. (2009) explains that occupational balance is influenced by a personalized component of engagement in challenging occupations as opposed to relaxation, which is characterized by

the personal preference for a certain amount of activity. In addition, understanding balance suggests that the preferred or healthy balance "buffers boredom" and that it comprises of meaningful variation of occupations that encourage learning. Thus, it has been suggested that in order for individuals "to be healthy, people need to be taught to create individualized balance of meaningful variation and redundancy via discovery, developing and acting on their own interests as well as by participating in rules, habits, rituals and cultures" (Yerxa,1998, p.415). This might be important for people who are no longer able to work but who might still be able to achieve a different sort of balance of occupations and activities (Stamm et al., 2009).

Critics about the importance of occupation in occupational therapy have indicated that "the division of all occupations into three simplistic categories of self-care, productivity, and leisure is arbitrary, lacks supportive evidence and promotes a doctrine of individualism" (Hammell, 2009, p.107). This could mean that occupational therapists should enabled older adults living with chronic diseases to inform them about the occupational categories that enhance their well-being.

Previous studies (Mthembu et al., 2015; Mthembu et al., 2016) indicated that older adults living with chronic diseases such as diabetes, arthritis and cardiac conditions tend to experience occupational imbalance. It has been found from the studies that the occupational imbalance appears to influence the family members of the older adults living in environment affected by poverty and lack of resources.

1.4 **Statement of the problem**

The research problem investigated in this study is the dearth of information available regarding the relationship between spirituality, health-related quality of life and occupational

balance among adults with chronic diseases in a South African context. Various studies have shown that spirituality plays a significant role in the lives of adults with chronic diseases (Whitford, Olver & Peterson, 2008; Tyszka & Farber, 2010; Mthembu, et al., 2014; Mthembu et al., 2015). In addition, occupational therapists might need to provide an effective occupational therapy services that includes reflection on how spirituality enable adult living with chronic diseases to cope with life (Tyszka & Farber, 2010; Tan, Wutthilert & O'Conner, 2011). However, despite the importance of spirituality in adults with chronic diseases, there is little known about the relationship between spirituality, health-related quality of life and occupational balance among adults with chronic diseases in the Western Cape, South Africa. Therefore, clinicians often feel ill equipped to be present to the suffering of patients and the overwhelmingly complicated social issues associated with care for patients with complex chronic issues and diseases (Puchalski, Vitillo, Hull & Reller, 2014).

1.5 Research questions

The main research questions addressed in this study that was conducted over two phases were:

How does spirituality relate to health-related quality of life and occupational balance of adults with chronic diseases?

What are the perceptions of adults with chronic diseases and the relationship between spirituality, health-related quality of life and occupational balance?

1.6 Aim and Objectives

1.6.1 Aim

The aim of the study was to examine the relationship between spirituality, health-related quality of life and occupational balance from the perspectives of adults living with chronic diseases.

1.6.2 Objectives

The objectives for phase one of the study were:

- To examine the perspectives on spirituality of adults living with chronic diseases
- To examine the perspectives on health related quality of life of adults living with chronic diseases
- To examine the perspectives on occupational balance of adults living with chronic diseases
- To determine the relationship between spirituality and health related quality of life among adults with chronic diseases
- To determine the relationship between spirituality and occupational balance among adults with chronic diseases

The objectives for phase two of the study were:

- To explore and describe the perceptions of adults with chronic diseases regarding the relationship between spirituality, health related quality of life and occupational balance.

Methodology: In this study, an explanotory sequential mixed methods design was utilised was to examine the relationship between spirituality, health-related quality of life and occupational balance among adults living with chronic diseases, as well as to explore and

describe the perceptions of adults living with chronic diseases regarding spirituality, health-related quality of life and occupational balance. The study was conducted over two phases. Phase One of the study consisted of a quantitative design, to examine the variables in relation to spirituality; health-related quality of life and occupational balance of adults living with chronic diseases. Phase Two of this study consisted of a qualitative design exploring and describing the perceptions of the adults with chronic diseases regarding spirituality, health related quality of life and occupational balance. It made use of four focus groups in order to gain an understanding of the factors determined in phase one based on the responses from the statistical tests.

1.7 Significance of the study

The significance of this study lies in its contribution to the professional development of researchers and clinicians working in practice as well as education. It further informs the improvement and development of occupational therapy specific therapeutic programmes and promotes evidence-based practice. Furthermore, the knowledge generated in this study is of value for occupational therapy clinicians, as it provides a deeper understanding of the spirituality of patients living with chronic illness, relating to their quality of health, and occupational balance thus informing current practice. It is particularly beneficial for therapeutic programmes as it can guide holistic programmes with adults and older adults facing challenges living with chronic illness. Hence, there could be better patient outcomes and they will benefit from their chosen daily living occupations.

In addition, this study highlights the importance of spirituality in occupational therapy practice, and can thus guide current academic programmes around the inclusion of spirituality in the curriculum to facilitate students' understanding of the impact of spirituality on persons living with chronic diseases. Furthermore, utilisation of evidence based practice will assist the

students to competently conduct assessments and provide appropriate intervention programmes. Furthermore, it could motivate future research in this subject area.

1.8 Outline

Chapter One provides the study background, research question, aim and objectives. This is followed by an introduction to the research methods that were utilised in the study

Chapter Two presents a detailed literature review pertaining to the study's theoretical framework.

Chapter Three explains the methodology and research design used in this study. It includes the data methods, sampling methods, participant recruitment, data collection, data analysis, trustworthiness and ethics procedures for the study.

Chapter Four presents the statistical data findings as the themes and categories as the themes and categories emerged through the thematic analysis.

Chapter Five presents a discussion of the findings by integrating phase one and two. The insights gained from the findings are highlighted and contextualised in the light of available literature.

Chapter Six presents the summary, recommendations and conclusion of the study. The study's limitations are discussed.

CHAPTER TWO

LITERATURE REVIEW

2 Introduction

In this chapter relevant theory relating to the theoretical framwork is discussed. This includes the Canadian Model of Occupational Performance and Engagement (CMOP-E) as the theoretical framework underpinning this study. In addition, literature pertaining to the study explores some of the writings that are significant to the broad areas of spirituality, occupational balance, health related quality of life, chronic illness and occupational therapy is reviewed. Furthermore, literature illustrating various perspectives regarding key concepts of spitituality, person,occupational and evironment is reviewed.

2.1 The Canadian Model of Occupational Performance and Engagement (CMOP-E)

The Canadian Model of Occupational Performance and Engagement (CMOP-E), is an occupational therapy conceptual framework that places spirituality at its centre, thereby forming the core of the model that connects the person, environment, and occupation (Polatajko, Townsend & Craik, 2007). Therefore, the CMOP-E recognises that spirituality is important to the person and appears to be enabling people to engage in their meaningful and purposeful occupations. This signifies that the CMOP-E acknowledges the connection between spirituality and client-centeredness (Polatajko et al., 2007). Thus, according to the CMOP-E the person comprises of three performance components namely; cognitive, affective and physical, with spirituality as the core of a person (Polatajko et al., 2007). The model further illustrates occupation as the link between the person and the environment. In addition,

occupation can be described as the driving force that enables acting on the environment and can be classified in the occupational areas of self-care, productivity and leisure (Polatajko et al., 2007).

The CMOP-E is a model that accommodates the humanistic, developmental and environmental theories (Polatajko et al., 2007). Therefore, the CMOP-E focusses on client centred principles, adaptation and development of occupational roles, as well as the influence of the environment on occupation and the person. Please see Figure 1 below for a diagrammatic representation of the CMOP-E:

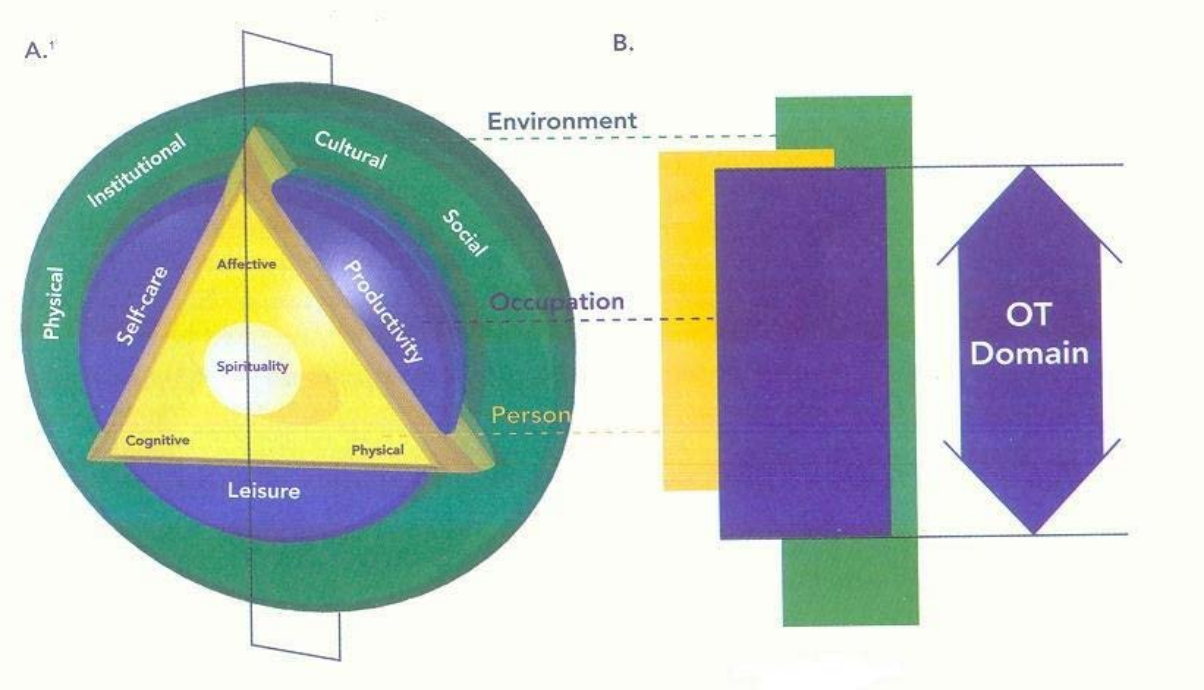


Figure 1: The CMOP-E: Specifying our domain of concern (Polatajko, Townsend & Craik, 2007)

Person: is represented by the centre of the triangle. The three performance components i.e. cognitive, affective and physical are located in the three corners of the triangle. The model illustrates that spirituality represents the essence of the inner self of the person and is not related to religion, but to occupations.

Environment: can be seen in the outer circle in the figure where the individual exists and where occupations take place. It is made up of physical, cultural, institutional and social environments.

Occupation: represented by the figure is in the middle circle, referred to as occupational purposes which are categorized by three components; self-care, productivity and leisure. In addition, occupation is described as the core domain of concern to occupational therapists. It is through occupations that the person interacts with the environment, therefore creating the association between the person and the context (Polatajko et al., 2007).

In the current study, the CMOP-E guided the interdependent relationship between the changes in the relationship between spirituality, health-related quality of life and occupational balance among adults living with chronic diseases, therefore allowing an understanding of occupational dysfunction. Townsend et al. (2007), states that the CMOP-E is geared towards guiding client-centred enablement which is based on principles of enabling and enablement-focussed occupation. Client-centred enablement involves achieving health and well-being through a supportive environment. The CMOP-E reflects that change can be directed to enable people to develop through occupational transitions during their lives by maintaining occupational engagement, health, well-being, and reinstating occupational potential and performance. Indicative of limitations in any of the components of the model, the outcome of this interdependent relationship becomes dysfunctional occupational performance or engagement. Function is signified by a supporting/satisfying interdependent relationship between the person, occupation and environment. The model also specifies the role that occupation plays in health and well-being and further broadens the scope of practice on creating environments that are occupationally supportive (Polatajko et al. 2007).

2.2 Spirituality in occupational therapy

In describing spiritualty in occupational therapy, previous studies highlight spirituality as one of the elements of a humanistic approach which appear to not be fairly addressed in practice (Mthembu et al, 2014; Collins, 2012; Jones, 2016; Mthembu, Wegner & Roman, 2017b). Mthembu et al. (2017b) and Jones (2016) accentuate the importance of the seven dimensions of spirituality in occupational therapy. The dimensions of spirituality in occupational therapy include suffering, becoming, meaning, being, centeredness, connectedness and transcendence. Therefore, these seven dimensions of spirituality could support occupational therapy clinicians, educators and students to have a better understanding of the spirituality and occupational injustices that individuals, groups, families and communities experience. Jones' study corroborates (2016) the findings of Mthembu et al. (2017b) which highlight the importance of spiritually-skilled occupational therapy practices that value spiritual well-being by facilitating engagement in spiritual occupations that address the seven dimensions of spirituality.

Previous studies have indicated that occupational therapists seemed to experience difficulties about how to consider spirituality into their practice (Jones, 2016; Mthembu et al., 2017b). This could be linked to a lack of integration of spirituality history taking in theory and practice. A cross-sectional study by Mthembu et al. (2014) examined that the perception of occupational therapy students about spirituality and found that there were no educational guidelines that may be used in occupational therapy practice. In addition, students in training indicated the limited covering of spirituality in their course concerning spirituality in order to develop their knowledge within occupational therapy. Thus, students in training were in support of spirituality to be instilled in their occupational therapy education as an important constituent of occupational performance.

2.3 Health related quality of life in adults with chronic diseases.

It appears that health related quality of life in adults with chronic diseases tend to be influenced by spirituality. A study conducted by White (2013) found that persons with chronic health related illnesses who are receiving treatment are more likely to engage in spiritual self-care practices to help them cope with their circumstances surrounding chronic diseases. Furthermore, spirituality and spiritual self-care both have positive influences on health and well-being of persons living with chronic diseases (White, 2013; Sulmasy 2002). According to White (2013), the self-care of persons living with chronic diseases include: activities of daily living, social participation, sleep, rest, work, leisure and managing on-going functional limitations. Therefore, these activities have significant implications for the individual's concept of quality of life that consists of the physical, emotional, and social factors held within the individual's perception of daily life (White, 2013; Adegbola, 2006).

Previous studies have reported on the importance of religion in health of people living with chronic illnesses such as renal disease, fibromyalgia, AIDS, arthritis and heart diseases (Adegbola, 2006; Kang, 2003). However, Adegbola (2006) noted that the dimensions of quality of life mentioned in White (2013) seemed to have omitted spirituality.

2.4 Spirituality and Health Related Quality of life

Recently, researchers have shown an increased interest in how spirituality can support health in the contexts of medicine, nursing, ethics, social work, and psychology (Puchalski et al., 2014; Kang, 2003). Spirituality appeared to be encompassed in various self-management practices (Harvey & Silverman, 2007). This is evident amongst individuals across the different race groupings who lives with chronic illness spirituality tend to play a vital part in

their health related quality of life and well-being (Mthembu et al., 2017a). On the other hand, previous studies (Stojković & Prlić, 2012; Da Rocha & Ciosak, 2014), reported that culture seemed to be another element that contribute to the religious and spiritual care of well-being and health quality of life of older people. Therefore, spirituality as one of religious and cultural practices is of great importance in helping people living with chronic illnesses to find meaning and purpose of life.

It should be noted that patients with chronic diseases tend to engage in prayer for relief from their physical and mental suffering, however, the purpose of engaging in prayers is not only for healing but for coping with their conditions (Jors, Büssing, Hvidt & Baumann, 2015). Nevertheless, in relation to health and well-being, Puchalski, et al. (2014) and Mthembu et al. (2016) highlighted the importance of connections with others as part of social well-being of persons living with chronic illness. This may mean that spirituality should be considered as an element that could add value to occupational balance of adults living with chronic diseases.

2.5 Occupational balance in adults with chronic diseases

In describing the term occupational balance, Stamm and colleagues (2009, p.33) consider occupational balance as an engagement "in different types of occupations in a dynamic way so that this individual mix of occupations leads to health and to high quality of life as experienced by the individual". Recently, studies have explored the concept of occupational balance and reported that it differs among people, and one's health is related with one's perceived ideal balance of physical, mental, social and rest occupations (Ekelman, Bazyk & Bazyk, 2013; & Hosseini, Sharif, Ahmadi, Zare, 2010). According to McDonald, Dietrich, Townsend and Backman (2012), many people eventually experience self-acceptance as they reflect on their life and illness. This is due to the process of accepting the chronic illness that

can take undefined periods of time. In addition, the study further describes activity interference in chronic illness as an all-inclusive affliction where even simple activities turn into an overwhelming challenge (Mcdonald et al., 2012).

There are three dimensions of occupational balance as identified by Stamm et al. (2009) which include 1) challenging versus relaxing occupations and activities; 2) activities meaningful for the individual and activities meaningful in a social context, and 3) activities intended to care for oneself and activities intended to care for others.

In the first dimension of challenging versus relaxing occupations and activities, Stamm et al. (2009) describe new challenges are perceived as new occupations that people with chronic illness are dealing with on a daily basis. However, there are new challenges that replace other meaningful activities.

Furthermore, the second dimension of activities meaningful for the individual and activities in a sociocultural context describes engaging in occupations which is regarded as personal choice but benefitting others.

Lastly, the third dimension about activities to care for oneself and activities intended to care for others indicates that the person with chronic illness engage in intention to care for one's body and spirit in a beneficial way, thus activities intended to care for oneself as well as to care for others by providing support and sharing.

A narrative study by Stamm and colleagues (2009) has found that experience of balance relates to the notion of being healthy, engaging in meaningful activities related to a sociocultural context of the individuals to care for oneself and others. Despite that occupational balance seemed to be significant but caregiver burden has been a controversial subject within the field of occupational therapy. This is evident in a study by Mthembu at al.

(2016) who explored the family caregivers' experiences of caring for an older adult living with chronic diseases and found that they tend to experience caregiver burden and occupational imbalance. Consequently, occupational imbalance influences health as individuals tend to be disrupted in their routines related to occupational performance and engagement (Stamm et. al., 2009).

2.6 Spirituality and occupational balance in adults with chronic diseases

It has been reported that there is a relationship between spirituality and occupational balance (Kang, 2003). Previous studies have highlighted the importance of spirituality as a coping mechanism for adults living with chronic diseases (Bredle, Salsman, Scott, Arnold & Cella et al, 2011; Mclntyre, Joubert & Ramklass, 2014; Offenbaecher et al., 2013). This is supported by Vallurupalli et al. (2011) who found that the connections between religious coping and spiritualty tend to enhance the positive attributes of quality of life of patients. Vallurupalli et al. (2011) together with Büssing, Balzat and Heusser (2010) further explain that the connections between patients' spiritual well-being and their beliefs seemed to promote physical, social, emotional and functional well-being. It could be an indication that there is a relationship between spirituality and occupational balance.

Although a study conducted by Vallurupalli et al. (2011) highlighted that adults living with chronic diseases achieve better quality of life through using spirituality as a coping mechanisms. However, Bredle et al. (2011) indicated that spirituality appears as a positive motivation for personal and relational aspects of human beings. Furthermore, the results of a study conducted by Bredle et al. (2011) showed that adults with higher levels of spiritual well-being, self-esteem, optimism and social support seem to enjoy life more than those with low spiritual well-being. Thus, the findings of these studies highlight clinicians may need to

acknowledge the vital role of spirituality and other concerns of persons living with chronic illness and how they balance their occupations.

Adults with chronic diseases face multiple challenges in balancing their occupational engagement related to their developmental stage as they need to find ways to control their diseases and to prevent serious complications (Stamm et al., 2009; Sawyer & Aroni, 2005). Several studies have indicated that older adults tend to engage in meaningful and spiritual occupations such as belief in a deity, prayer and meditation to enhance their health, quality of life and well-being within their time and space (Nilsson et al., 2013; Hwang & Nochajiki, 2003; Scheurich, 2003; Kang, 2003; Bennett, 2005; Levasseur et al., 2008).

2.7 Summary

The reviewed literature acknowledges that the CMOP-E recognises that spirituality is an important element of the person that enables people to engage in their meaningful and purposeful occupations. Spirituality is comprised of seven dimensions namely; suffering, becoming; meaning; being; centeredness; connectedness and transcendence. Therefore, spirituality and spiritual self-care both have positive influences on health and well-being of persons living with chronic diseases. Persons living with chronic diseases engage in a variety of areas of occupation such as basic activities of daily living, instrumental activities of daily living, social participation, sleep, rest, work and leisure and managing on-going functional limitations. Furthermore, spirituality is combined with self-management practice with persons living with chronic illness to enhance ageing, religion, health state and culture which contribute to their religious and well-being and health quality. This indicates that there might be a need of occupational balance between patients' spiritual well-being as related to their beliefs and practices and their physical, social, emotional and functional well-being.

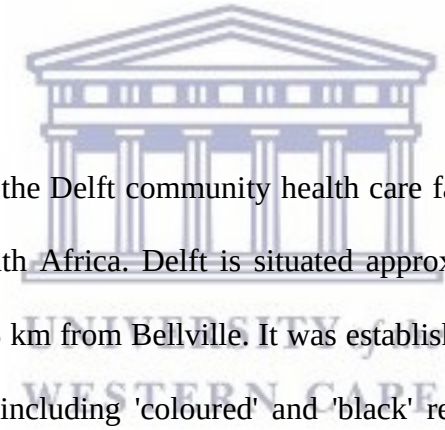
Spirituality may possibly have comprehensive importance across various patient populations, patients seem to predominantly identify themselves as spiritual, with religious expressions. These results are consistent with the findings of the study indicating a positive relationship between the meaning and peace dimensions of spirituality and patient quality of life.

CHAPTER THREE

METHODOLOGY

3 Introduction

In this chapter, a description of the methodology utilised in phase one and phase two of this study is presented. This section covers the research setting, pragmatic worldview, study approach, research design, study population, sample size, sampling procedure, data collection and processing, data analysis, validity, pilot study and reliability, as well as ethical considerations.



3.1 Research Setting

This study was conducted in the Delft community health care facility which is located in the Western Cape Province, South Africa. Delft is situated approximately 34 km east of Cape Town, and approximately 7.5 km from Bellville. It was established to be one of Cape Town's first mixed Race Township including 'coloured' and 'black' residents. The majority of the dwellings are houses or brick structures with a yard and private electricity and piped water. Most residents are from Cape Town or the surrounding areas in the Western Cape Province. Delft areas include The Hague, Roosendal, Voordbrug, Eindhoven, Delft South, Blikkiesdorp informal settlement (They consist of shacks and have limited access to the water and Sanitary facilities with no electricity supply), recently new developing areas N2 gateway. Surrounding areas are Belhar, Wes bank, Bishop Lavis, Silversands and Sarepta which is a suburb of kuilsriver. According to the 2011 census, Delft was 51% Coloured and 46% Black African with 3% other (City of Cape Town, Census 2011). The dominant first languages are Afrikaans and Xhosa, while English is widely used as second language. Delft has 22 schools

which consist of 15 primary schools, 7 secondary schools (of which 1is a Skills School) and 1 special needs school (Oasis). Community members are able to access shops in the main road. There are also many spaza shops as well as street vendors in the Delft community. The community faces challenges on a daily basis, such as unemployment, gangsterism, broken families, child abuse, rape, poor housing and illiteracy. Thus, their primary focus is to survive, hence basic needs are priority for them. Delft CHC services a population of about 152,030. Therefore, it places a huge burden on health care. It is a primary health care outpatient facility which is accessible to the community and its neighbouring areas. The facility provides preventative, curative and health promotive services to the community. The health status of the community is of great concern but introspective of the socio-economic burden of our society. The main prevalence of illness in the community is chronic illnesses, such as diabetes mellitus, HIV, hypertension with heart ailments and asthmatic illnesses (Waggie, 2008; Mongwe, 2002; Western Cape Government Annual Health Report 2015/2014).

3.2 Pragmatism worldview

In this research methodology, both quantitative and qualitative approaches were two main traditional methods, which are accommodated by the mixed methods approach (Creswell, 2009). While philosophical ideas remain largely hidden in research, they still influence the practice of research and need to be acknowledged. Worldviews arise based on discipline orientation, student mentor preferences, and past research practices. Therefore, the types of views held by different researchers centred on these factors, will often lead to embracing a qualitative, quantitative, or mixed methods approach in their research. Although there is constant discussion about what worldviews researchers bring to inquiry. The Pragmatism philosophy concerns the rationale that selecting between one position (epistemology, ontology, or axiology) and the other is rather impractical in practice; and it is argued that the

most significant determining factor of which position to adopt is the research question (Creswell & Plano Clark, 2011; Saunders, Lewis, & Thornhill, 2009). Thus, this is predominantly relevant where the research question does not suggest clearly that either a positivist or interpretive philosophy should be adopted in an inquiry, for example, within an epistemological perspective. Therefore, in this philosophical quarrel, the use of both qualitative and quantitative methods to resolve a real-life world challenge is commended. Pragmatism researcher is external, multiple, and the view is that it is chosen to best answer the research questions. Either subjective or objective meanings can provide facts to a research question with focus on practical application of issues by merging views to help interpret data. Principles play a significant role to interpret results using subjective and objective reasoning, thus using both quantitative and qualitative approaches, or mixed and multiple methods (Ihuah & Eaton, October 2013). Moreover, there are many forms of this philosophy, but for many, pragmatism as a worldview arises out of actions, situations, and consequences rather than antecedent condition (as in postpositivism). However, there is a concern with applications regarding what works and solutions to problems (Patton, 1990). Thus, instead of concentrating on methods, researchers lay emphasis on the research problem and use all approaches available to understand the problem (Rossman & Wilson, 1985).

As a philosophical foundation for mixed methods studies, Morgan (2007), Patton (1990), and Tashakkori and Teddlie (2010) carry its significance for focusing attention on the research problem in social science research and then using homogeneous approaches to derive knowledge about the problem. There is a consensus among Cherry Holmes (1992), Morgan (2007), as well as Creswell (2005), regarding their view on pragmatism in that it provides a philosophical basis for research. Pragmatism is not focussed on any one system of philosophy and reality. Thus, it applies to mixed methods research in that inquirers draw profusely from both quantitative and qualitative assumptions when they engage in their research (Creswell,

2014). Therefore, allowing researchers to choose the methods, techniques, and procedures of research that best meet their requirements and purposes. Similarly, mixed methods researchers review many approaches for collecting and analysing data rather than subscribing to only one way. Thus, in mixed methods research, investigators use both quantitative and qualitative data because they work to provide the best understanding of a research problem. Moreover, pragmatist researchers look at the how and what to research based on the intended consequence. They need to establish a purpose for their mixed methods, and a rationale why quantitative and qualitative data are essential to be mixed initially (Creswell, 2014). Pragmatists are in agreement that research always occurs in social, historical, political, and other contexts (Creswell, 2014). In this way, mixed methods studies may include a postmodern turn and a theoretical lens that is reflective of social justice and political purposes. Consequently, for the mixed methods researcher, pragmatism unlocks the entree to multiple methods, different worldviews, and different assumptions, as well as different forms of data collection and analysis (Creswell, 2014).

3.3 Research Approach

The research approach taken in this study is a mixed methods approach based on a combination of quantitative and qualitative approaches. Furthermore, mixed methods were used to combine quantitative and qualitative methods to obtain a better understanding of research phenomena. According to Creswell (2002) and Shneerson and Gale (2015), the combination of quantitative and qualitative methods in mixed-methods research complements each other and allows for a more complete analysis. Therefore, the pragmatic worldview promotes the adoption of mixed methods as the data collection method which opens the opportunity to be objective and subjective in analysing the points of view of the participants

(Saunders et al., 2009). The quantitative study assisted to generate qualitative research questions and produced results which could be explored in contextual and real-life settings. In order to fully analyse a phenomenon, it is vital and necessary to support the inductive approach with deductive thinking to tackle a real-life problem such as in the case of this research. A mixed-method research design was employed by addressing the issues of priority, implementation, and integration of the quantitative and qualitative approaches (Ivankova, Creswell & Stick, 2006).

3.3.1 Priority

A combination of quantitative and qualitative approaches was used in the data collection. In describing priority, Ivankova et al. (2006) refers to priority as to which approach, quantitative or qualitative (or both), a researcher gives more weight or attention through the data collection and analysis process in this study. Therefore, in this study, a sequential explanatory design was used with a priority given to the quantitative approach because the quantitative data comes first in the sequence (Ivankova et. al., 2006).

The first, quantitative phase**,** of the study focused on a cross-sectional study to examine the relationship between spirituality, health-related quality of life and occupational balance from the perspectives of adults living with chronic diseases. In addition, the second phase was to explore and interpret the statistical results obtained in the first quantitative phase regarding the relationship between spirituality, health related quality of life and occupational balance.

3.3.2 Implementation

In relation to the issue of implementation, Ivankova and colleagues (2006), consider implementation as a when quantitative and qualitative data collection and analysis follow one

another or occurs concurrently. In the current study, the quantitative phase incorporated data collection using a questionnaire.

3.3.3 Integration

Integration refers to the stages where the mixing of quantitative and qualitative methods occurs in a sequential explanatory mixed-method study approach (Ivankova et. al., 2006). Therefore, there is a variety of possibilities for mixing namely during formulation of the study purpose and when introducing both quantitative and qualitative researcher questions. In addition, mixing could happen during the interpretation stage of the study' results of quantitative and qualitative phases. For the purpose of the study, integration occurred in the formulation of the questions of the second phase and during the interpretation of the findings from phase one and phase two.

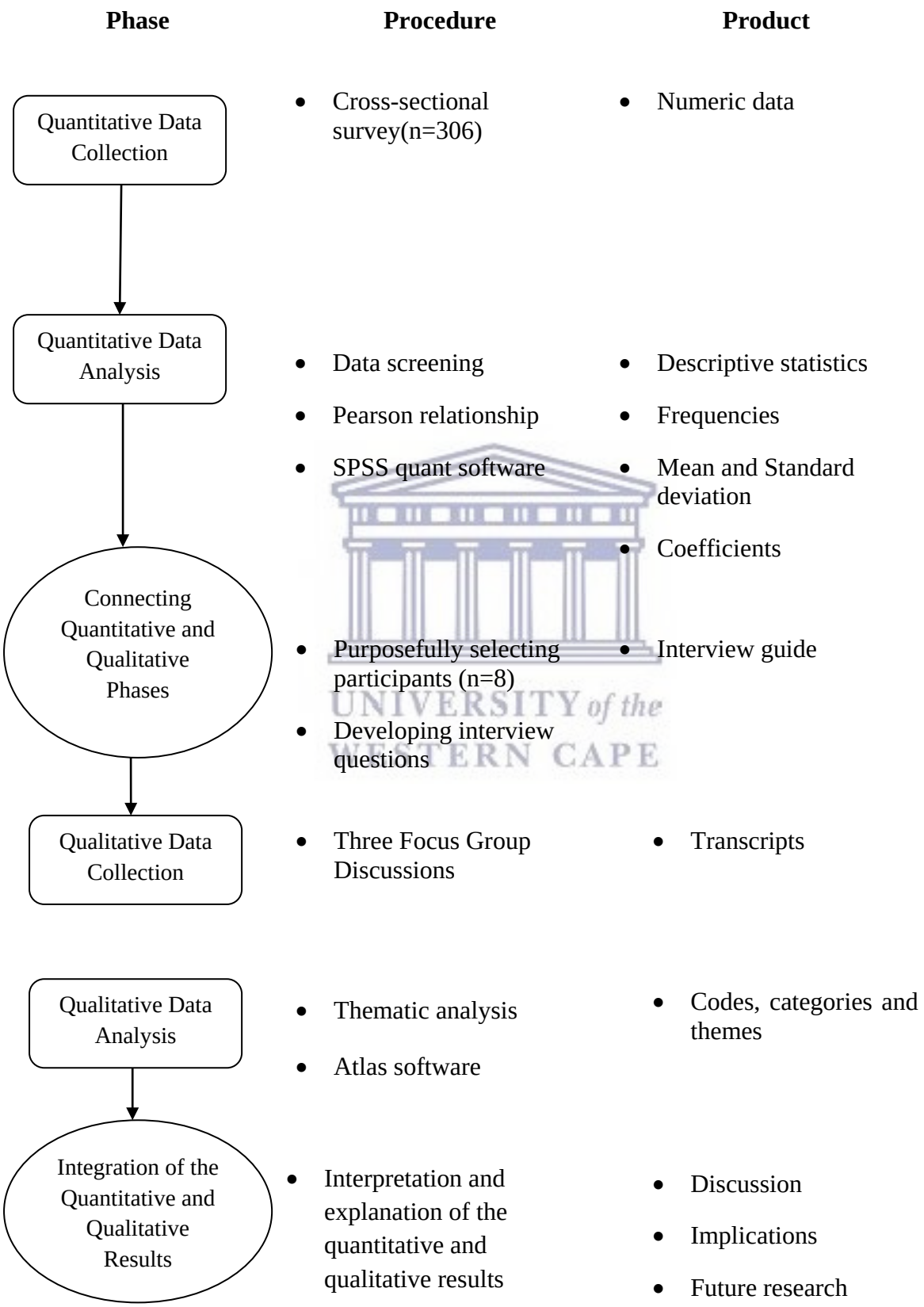
3.4 Research Design

The research design is the overall plan for connecting the conceptual research problems to the pertinent (and achievable) empirical research (Van Wyk, 2012). For the purpose of this study, a sequential explanatory mixed methods research design that involves two phases was used (Johnson & Onwuegbuzie, 2004; Creswell & Clark, 2007). The two phases include a procedure for collecting, analysing and "mixing" both quantitative and qualitative data (Creswell, 2014; Ivankova et. al., 2006). Sequential explanatory mixed methods are unique in which the researcher first conducts quantitative research, by collecting analysing quantitative data. In addition, the qualitative data are collected and analysed second in the sequence in order to help explain, or elaborate on, the quantitative results obtained in the first phase (Creswell, 2014; Ivankova et. al., 2006). The sequential mixed-methods approach that was

employed in this study comprised two phases quantitative and qualitative as presented below. Figure 2 below provides a graphical representation of the mixed-methods sequential explanatory design procedures used for the illustrative study.

Figure 2:

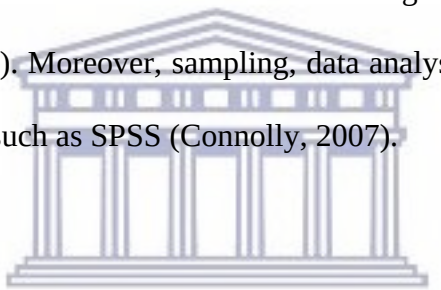
Visual Model for Mixed-Methods: Sequential Explanatory Design Procedures



3.5 Phase One: Quantitative Phase

3.5.1 Design: Cross-sectional correlation

A cross-sectional correlation research design was used for phase one of the study in order to examine the relationship between spirituality, health-related quality of life and occupational balance among adults with chronic diseases. According to Grove, Burns and Gray (2013), a cross-sectional correlation design is employed to examine the relationships between diseases, other health related characteristics, and variables. However, a correlation design may assist in examining the strength of the relationships between the variables (Clamp, Gough & Land, 2004). The advantages of quantitative findings are likely to be widespread to a whole population or a sub-population because it involves the larger sample that appears to be randomly selected (Carr, 1994). Moreover, sampling, data analysis is less time consuming as it uses the statistical software such as SPSS (Connolly, 2007).



3.5.2 Population

The target population in this study was adults between the ages of 18 years and late adulthood living with chronic diseases that access outpatient primary health care services at the Delft community health facility. A sample size was calculated using Raosoft sample size calculator. The margin error of 5% was used with 95% confidence levels within a population size of approximately 2000 adults living with chronic diseases. The response distribution of 50% was used in this study. A total of 320 participants were computed from the Raosoft sample size calculator.

3.5.3 Sample

A convenient sampling method was used to recruit the 323 sample of participants. The participants accessing the primary health care facility during the period of the study were recruited via the occupational therapy services rendered at the primary health care setting. Convenience samples are sometimes regarded as 'accidental samples' because fundamentals may be carefully chosen in the sample merely as they just happen to be situated, spatially or administratively (Etikan, Alkassim, & Abubakr, 2015). Thus, Etikan et al. (2015) explain that convenience sampling is a form of non-probability or non-random sampling where members of the target population meet certain practical criteria, such as easy accessibility, geographical surrounding area, availability at a given time, or the preparedness to participate. The participants who were aged between 18 years to late adulthood diagnosed with chronic illness while receiving treatment at the Delft CHC were included in the study. Children who were visiting the health centre were excluded in the study.

3.5.4 Data collection

A self-administered questionnaire was used to collect the data from the participants. Assistance was provided to participants that required assistance with reading, writing or translating in their respective languages and explaining words used within the questionnaires. Thus, making certain that the word use was understood by the participants. The language spoken and literacy level was taken into cognisance. The questionnaire used was fourfold (Appendix 1): Part A: socio-demographics, Part B: Occupational Balance-Questionnaire, Part C: Functional Assessment of Chronic Illness Therapy-Spiritual Well-Being (FACIT-Sp-12), and Part D: Spiritual Needs Questionnaire (SpNQ). The instrument used was formulated by previous researchers who were investigating chronic illness and the connection with spirituality. Therefore, the validity of the instrument was tested with participants who were

not part of the study. The instruments were found to be valid and reliable for the population in the South African context.

Demographics: participants were asked to provide their age, gender, race, marital status, religion, level of education, diagnosis and economic level.

Measurement tools (Appendix 1)

Occupational Balance (OB-Quest) is a 10-item Likert-type questionnaire designed to measure occupational balance. The Cronbach alpha (α =0.57) and permission provided by Prof. T.A Stamm (Dür et al., 2014).

Functional Assessment of Chronic Illness Therapy-Spiritual Well-Being (FACIT-Sp-12) is a 12-item Likert-type questionnaire designed to measure health related quality of life of people with chronic diseases, physical well-being, social/family well-being, emotional well-being and functional well-being. The Cronbach alpha of the instrument 5-point Likert scale, which was developed and tested to be valid and reliable (α = to be covered) by (Cella, 2007). Permission to use questionnaire has been granted.

Spiritual Needs Questionnaire (SpNQ) is 27-items with four main factors with Cronbach alpha are: Factor 1 Religious (α =0.92), Factor 2 Inner Peace (α =0.82), Factor 3 Existential (α =.82) and Factor Actively (α =0.74) (Büssing, Balzat & Heusser, 2010). The reliability of this instrument ranges from Cronbach's alpha (α = 0.74 to 0.92). Permission to use the questionnaire has been granted.

3.5.5 Pilot study

A pilot study was conducted to assist the researcher in determining any flaws, limitations, or other weaknesses within the questionnaire design and this allowed the researcher to make necessary adjustments prior to the implementation of the study (Kvale, 2007). The researcher therefore selected 10 % of the people living with chronic diseases who were not going to be part of the main study. The participants seemed to struggle with demographics specifically about choosing level income marital status. The pilot study also assisted the researchers to make amendments on the research questions specifically with relation to the demographics questionnaire so that it could be easily understood by the participants.

3.5.6 Data analysis

In order to analyse data, descriptive and inferential statistical tests were used. In descriptive statistics analysis, frequencies, percentages, graphs, means, and standard deviations are investigated and Pearson inferential statistics used include correlation analyses to examine the relationships between the variables. All analysis was conducted by means of Statistical Package for the Social Sciences (SPSS). In preparation for the data analyses, the data was cleaned for accuracy of results. Firstly, coding was done in preparation for computing the responses on the excel spread sheet. All analysis for the descriptive were computed in the SPSS. Lastly coefficient variables was produced through the use of the SSPS programme.

3.5.7 Reliability and Validity

Validity refers to the degree to which a study accurately reflects or assesses the specific concept or construct that the researcher is attempting to measure (Thorndike, 1997). Criterion-related validity, also referred to as instrumental or predictive validity, issued to

demonstrate the accuracy of a measure or procedure by comparing it with another measure or procedure, which has been demonstrated to be valid (Overview: Reliability and Validity, 2001). Reliability refers to the accuracy and precision of a measurement procedure (Thorndike, 1997). The test-retest reliability of the survey instrument was obtained through testing of the instrument with the 10% of the people living with chronic disease. For the purpose of this study, existing questionnaires were used to enhance validity and to ensure the accuracy and measurement procedure through the first phase of the study.

3.6 **Phase Two: Qualitative Phase**

3.6.1 Research Design:

An exploratory-descriptive qualitative research design was utilised to gain the perspectives of adults with chronic diseases in relation to spirituality, health related quality of life and occupational engagement. Additionally, this approach was employed to generate an understanding of adults with chronic diseases' perceptions regarding spirituality, health related quality of life and occupational balance (Gray, Grove & Burns, 2013). Therefore, some advantages of using qualitative research approach is that qualitative research produces a concentrated detailed description of participants' feelings, opinions, and experiences, and interprets the meanings of their actions (Rahman, 2017). Thus, qualitative research results offer the relationship of information processing with performance specifically and deeply (Bachman, 1998). Other researchers argue that qualitative research approach (interpretivism) holistically provide understanding of the human experience in specific settings. Denzin and Lincoln (2002) and Rahman (2017) point out that a qualitative research is an interdisciplinary field, which comprises a widespread range of epistemological perspectives, research methods, and interpretive systems of understanding of human experiences.

3.6.2 Population

The population of this study was adults between the ages of 18 years and late adulthood diagnosed and receiving treatment for chronic diseases that utilise the primary health care services at the Delft community health facility.

3.6.3 Participant selection and recruitment

A purposive sampling method was used to recruit participants according to the following criteria: adults living with chronic diseases, both male and female. Literature defines purposive sampling, as the deliberate choice of a participant due to the potentials the participant holds (Creswell, 2014). A non-probability method does not need underlying philosophies or a set number of participants. Thus, the researcher decides what needs to be known and sets out to find people who can and are eager to offer the information by assisting with knowledge or experience. Furthermore, it involves identification and selection of persons or groups of individuals that is capable and well-informed with an occurrence of interest (Etikan, Musa, & Alkassim, 2016).

The researcher identified and selected 10 probable participants who met the study criteria. The participants who were contacted and informed about the study were invited and given an opportunity to partake in the study. In addition, those that agreed completed a consent form. Thus, 8 participants were willing to share their experience and knowledge for the purpose of the study.

In this study, the inclusion criteria used to select the participants comprised the following: firstly, the participants needed to reside in the Delft community or surrounding areas accessing the Delft community health centre. Furthermore, participants were between the ages of young adulthood to late adulthood. In addition, the participants must have been diagnosed with one or more chronic disease both male and female. In the current study the

participants that consented in participating in the focus group discussions were aged between 25-68years of age living with chronic diseases. There were two male participants and 6 female's participants of which were African and people of colour.

3.6.4 Data collection

Focus Group Discussions (FGDs) were conducted for the intention of the data collection method used in the second phase of the sequential explanatory mixed methods. The FGDs were conducted so that the descriptive and statistical tests of the first phase (quantitative phase) could be explained further from the perspectives of the participants. Three FGDs were conducted for collecting qualitative data from participants at the health care centre by ensuring that the participants' privacy and confidentiality were respected.

An interview guide (Appendix 11) was employed in order to guide the qualitative phase while conducting the three FGDs. The open-ended questions were derived from the factors and statistical test results of phase one. Furthermore, to determine the connection of the perspectives of adults with chronic diseases in relation to spirituality, health related quality of life and occupational engagement. It is highlighted that during FGDs, there can be group dynamics that might assist in generating a new thinking about a topic, which could result in a much more in-depth discussion (Morgan, 2013). The FGDs indeed assisted the researcher to enable the participants to share their perspectives more in-depth.

3.6.5 Data analysis

Thematic analysis was used to analyse the data as described by Braun and Clarke (2006). Figure 3 below provides an illustration of this process of thematic analysis that included familiarization, coding, searching for themes, reviewing of themes, defining and naming of themes and lastly, writing up of the research report. The researcher familiarized herself with the data by reading and re-reading the data and by listening to the audio-recorded data and

analytic observations made. The researcher coded every item and ended by collating all the codes and relevant data extracts. The researcher used an active process to identify similarity of codes in the data. The phase ended by collating the coded data relevant to each theme and checking the themes in relation to both the coded extracts and the full data-set.

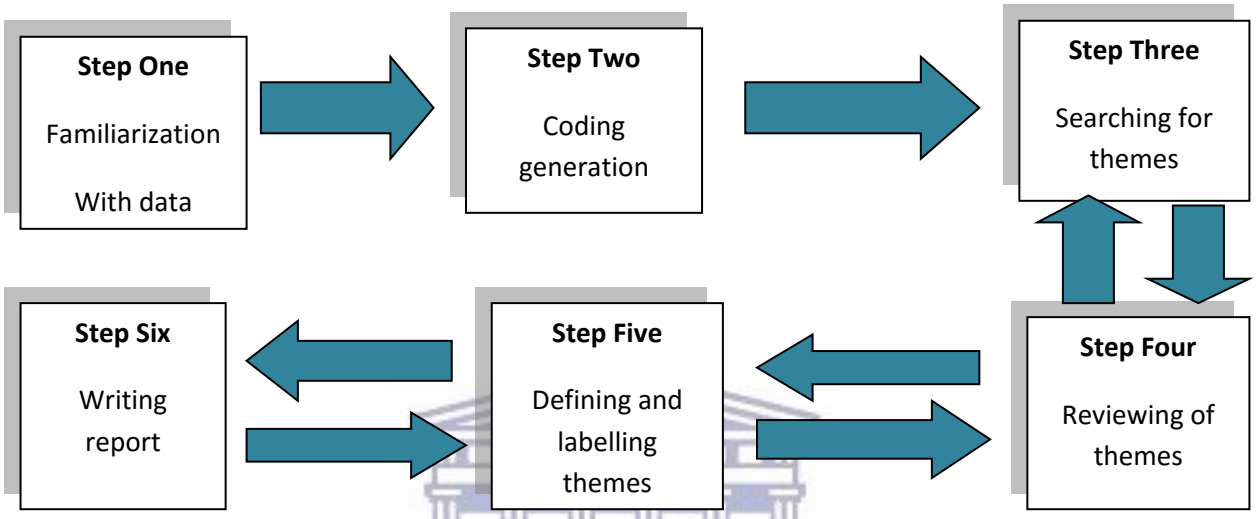


Figure 3: Six steps of thematic analysis of the current study (Braun & Clark, 2006)

Step One: Familiarisation with the data

In relation to step one, the researcher was involved with the facilitation of focus group discussions and became actively involved in the compilation of the data collection. This allowed the researcher to become grossly familiar with the data. The process of the researcher being actively involved amplified the researcher's understanding of and insight into the perspectives of the participants regarding the relationship between spirituality, health-related quality of life and occupational balance among adults with chronic diseases. Furthermore, the researcher transcribed the recordings in order to become familiar with the data, thus formulating ideas around the discussion of the study and assisted with developing the researcher's understanding of the content of the qualitative data. This step was important for the researcher to captivate the responses and improve concepts, ideas and patterns for

analysis. Therefore, the researcher repeatedly read the data to search for meanings and patterns. According to Braun and Clark (2006), it is essential that the researcher is submerged in the data in order to become familiar with the scope and extent of the content. This involves repeated reading of the data, and reading the data in an active way searching for meanings, patterns and so on. In addition, it is important to read through the entire data set at least once before you begin your coding, as your ideas and recognition of possible patterns will be formed as you read through.

Step Two: Initial codes generation

The second step comprised of generating codes using the transcripts by using the process of breaking down the qualitative data into different parts, organizing into meaningful groups, and coding these by using in vivo coding, process coding and other coding methods (Braun & Clark, 2006). The researcher analysed the set of data with the use of the Atlas software programme to search for similarities and differences and coded them into meaningful groups. The researcher used the code manager in order to create families of the codes. The software allowed the researcher to rename the codes.

Step Three: Searching for themes based on the initial coding

In this third step, the researcher continued to use the Atlas software in order to break down numerous coding into a constructive manner. The software permitted the researcher to breakdown the codes and construct new families known as themes in qualitative language. The researcher then read, sorted and checked the relationship among the codes in a family based on their content. The families were generated and directed a second level of understanding of the transcript where the researcher determined the relationships and connections between the families. Braun and Clark (2006) illustrate that in this phase the

analysis should once again concentrate on the broader level of theme, rather than codes. It included organising the different codes into probable themes and organizing significant coded data extracts within identified themes.

Step Four: Reviewing themes

In this step, the researcher met with the supervisors to discuss and debate, check the themes, as well as question the processes that were followed in order to create the themes. The researcher then divided the themes into categories and subcategories in order to provide widespread analysis. After reviewing the themes several times, the researcher ensured that the themes were logical and coherent.

Step Five: Defining and labelling themes

In this step, the researcher made adjustments to the themes based on the information that emerged from the member checking with the participants to enhance the credibility of the findings. The researcher and supervisors examined the themes and provided their interpretations as independent assessors of the development. The themes were clearly defined, as further refinement of that theme as may have been needed. Themes were organized into a comprehensible and consistent description of the participants' views (Braun & Clark, 2006).

Step Six: Writing report

Braun and Clark (2006) explain that it is imperative that the analysis (the write-up of it, including data extracts) delivers a concise, comprehensible, logical, non- repetitive, and thought-provoking account of the story contained by and across themes. Furthermore, he illustrates that the write-up should deliver acceptable evidence of the themes within the data, enough data extracts to determine the prevalence of the theme. In addition, the extracts need

to be entrenched within an analytic narrative that captivating exemplifies the story that you are telling about your data, and your analytic narrative needs to go beyond description of the data, and make an argument in relation to your research question. In this step, the researcher wrote a report in a narrative form to exemplify the analysis using extracts from the data.

3.6.6 Trustworthiness

Trustworthiness is considered as the truth-value, which allows the researcher to recognize assurance in the truth of the findings through analysis and accurate interpretations of participant's experience to ensure credibility (Klopper, 2008; Krefting, 1991). Truth-value was established through credibility, applicability was amplified by means of transferability, consistency was reinforced by applying dependability, and neutrality was enriched through confirmability.

Credibility

According to Anney (2014), credibility can be defined as the self-reliance that can be placed in the truth of the research findings. Furthermore, credibility institutes whether or not the research findings signify feasible information extracted from the participants' original data and is a correct understanding of the participants' original views. To ensure credibility, the focus group discussions were held for 45-60 min per session with the participants on different days. In addition, a tape recorder was used to record all data of the focus group discussions. The researcher and supervisors sat to reach agreement on the findings and results.

- **Prolonged engagement**: the researcher is a clinician who is employed to provide intervention to persons with chronic illness. The researcher established rapport and engaged with participants throughout the facilitation of focus groups with the participants living with chronic illness to gain an understanding of the relationship

between spirituality, health related quality of life and occupational balance. The researcher spent enough time as part of data collected and analysis.

Triangulation: Triangulation is a method of refining the probability that findings and interpretations are found credible. There are four different types of triangulation described in research literature: data triangulation, investigator triangulation, theoretical triangulation and methodological triangulation (Klopper, 2008; Krefting, 1991). In this study, confirmability was ensured by keeping a rigorous record of the research process and trail of data analysis throughout this study. Methodological triangulation was used through the facilitation of focus group discussions with the participants, recording of data using the tape recorder, which allowed the researcher to listen and reflect on the discussions that was held. In order to achieve saturation of data, for this study, data was collected until the focus group discussions had comparable reactions in relation to the discussions conducted. Follow up focus group discussions were facilitated in order to enrich the data collected in the year 2017. Followed transcribing of the recordings transcriptions were read a few times to develop codes, re-coding, themes and then formulating themes into sub themes and categories.

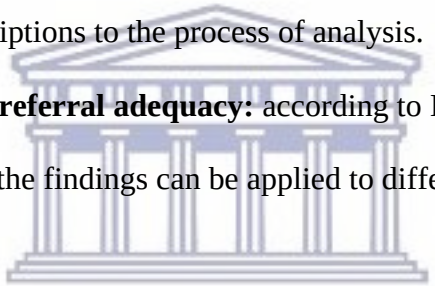
Member checking: · Member checking is defined as a method that includes constantly authenticating the data, analytic categories, interpretations and conclusions with the participants (Krefting, 1991; Klopper, 2008). In this study, the researcher conducted member checking with the participants after transcription. The results were made available to participants for confirmation post analysis. The researcher was supervised during the process of data collection and peer debriefing was used to discuss issues of concern, so that the researcher could confirm that the description given by the participant was correctly understood and validated the information and experience provided.

Dependability

According to literature, dependability can be defined as the consistency, stability and reliability of the research findings to the point which research procedures are documented. Moreover, allowing the research to be followed by an external source, audit, and critique of the research process (Moon, Brewer, Januchowski-Hartley, Adams & Blackman, 2016; Anney, 2014).

Atlas.ti7 was used as a software to managed data while analysing through the six steps of Braun and Clark (2006). This strengthen the analysis process as part of audit trail in order to track the progress from transcriptions to the process of analysis.

Authority of researcher and referral adequacy: according to Klopper, (2008), applicability represents the extent to which the findings can be applied to different contexts and groups.



Transferability is generally understood as a type of outward validation, which refers to the degree to which the phenomenon or findings are explained in one study. In addition, it is applicable or useful to theory, practice, and future research where it can be transferred to other contexts, (Moon, Brewer, Januchowski-Hartley, Adams and Blackman, 2016; Anney, 2014).

Transferability was ensured through a detailed description of the research process and the use of purposive sampling to select participants who have chronic related health illnesses (Mthobeni & Peu, 2013).

3.7 Ethics Statement

Ethics approval was sought from the Senate Research Committee of the University of the Western Cape. The ethics clearance numbers is 17/7/78 (Appendix 1). Subsequent to this approval, permission to conduct the study was requested from the Metro District Community health care facility management structure where the study took place (Appendix 2). Participation in the study was voluntary and participants were provided with an information sheet explaining the purpose of the study, requesting their participation and assuring them confidentiality (Appendix 3). Participants were asked for informed consent to participate in the survey (Appendix 4) and focus group discussion (Appendix 5). The participants had the right to withdraw from the study at any time without repercussion. Their right to anonymity and confidentiality was assured during dissemination of results by using pseudonyms to protect the identity of the participants and the research setting. The participants were informed that no harm could be expected from the study. All human interactions, however, carry some amount of risk, therefore, care was taken to minimise such risks and it was arranged that where necessary, participants who showed signs of any discomfort were referred to a suitable professional at the Delft community Health Center for assistance or intervention.

CHAPTER FOUR

RESULTS

4 Introduction

The results of the study are presented based on the two phases of the sequential explanatory mixed methods.

4.1 PHASE ONE: QUANTITATIVE RESULTS

In the first phase of the quantitative results, the sociodemographic characteristics, occupational balance, health related quality of life and spiritual needs are presented.

4.2 Sociodemographic characteristics of the study participants

A total of 306 participants living with chronic illness who use the Delft Community Health Centre participated in the study as presented in Table 1. The mean age of the participants was 49.3 years with a standard deviation of 10.74 years. The median age was 52.0 years. The majority of the participants were females (n=219, 71.6%) and there were males (n=87, 28.4%) of which (n=133, 43.8%) of participants were married or living with a partner (n=1, 0.3%) while (n=99, 32.4%) reported being single and (n=32, 10.5%) were divorced. There were others that reported that they were widows (n=20, 6.5%) and widowers (n=2, 0.7%) as well as separated (n=19, 6.2%). More than half of the participants (n=171, 55.9%) had secondary education, (n=120, 39.2%) primary and (n=10, 3.3%) had tertiary qualifications. (n=4, 1.3%) participants were illiterate and (n=1, 0.3%) had special schooling. Majority of the participants unemployed (n=155, 50.7%), disability grants (n=102, 33.3%), pensioners (n=23, 7.5%). There were participants who were employed, and reported that they were earning an income between R500-R3000 per month (n=22, 7.2%).

Table 1: Demographic characteristics of the participants (N=306)

Variable	N (%)	Mean± Standard Deviation
Age in years	**-**	**49.3±10.742**
18-30	24(7.8%)	
31-40	34(11.3%)	
41-50	80(24.9%)	
51-60	142(46. %)	
> 60	26(6.95%)	
Gender		
Male	87(28.4%)	
Female	219(71.6%)	
Race		
African	83(27.1%)	
Coloured	221(72.2%)	
Indian	2(0.7%)	
Marital Status		
Single	99(32.4%)	
Married	133(43.5%)	
Divorced	32(10.5%)	
Widow	20(6.5%)	
Widower	2(0.7%)	
Separated	19(6.2%)	
Cohabitation	1(0.3%)	
Level of Education		
Illiterate	4(1.3%)	
Primary	120(39.2%)	
Secondary	171(55.9%)	
Tertiary	10(3.3%)	
Special School	1(0.3%)	
Economic Status		
Disability Grant	102(33.3%)	
Pension	23(7.5%)	
Unemployed	155(50.7%)	
R500-3000	22(7.5%)	
R6000-8000	2(0.7%)	
R10000-20000	2(0.7%)	

4.3 Chronic diseases prevalence

There were varieties of chronic diseases that were reported by the study participants. Table 2 presents the prevalence of the chronic diseases that the participants had within the current study.

Table 2: Chronic Diseases prevalence

Chronic Diseases	Frequencies (N)
Diabetes	43(14%)
Hypertension	157(51.3%)
Stroke	34(11.11%)
Cholesterol	24(7.84%)
Epilepsy	14(4.57%)
Gastro-oesophageal reflux disease	5(1.63%)
Chronic lower back pain	27(8.82%)
Heart conditions	10(3.26%)
HIV	47(15.35%)
Cancer	7(2.28%)
Arthritis	101(33%)
Parkinson's	2(0.6%)
Chronic obstructive pulmonary disease	10(3.26%)
Major depressive disorder	11(3.59%)
Bipolar mood disorder	6(1.96%)
Asthma	29(9.47%)
Schizophrenia	11(3.59%)

4.4 Participants' beliefs system

In relation to the participants' spiritual and religious beliefs, majority of the participants reported that they have religion (n=289, 94.8%) and (n=16, 5.2%) reported that they have no religion as presented in Figure 4 below.

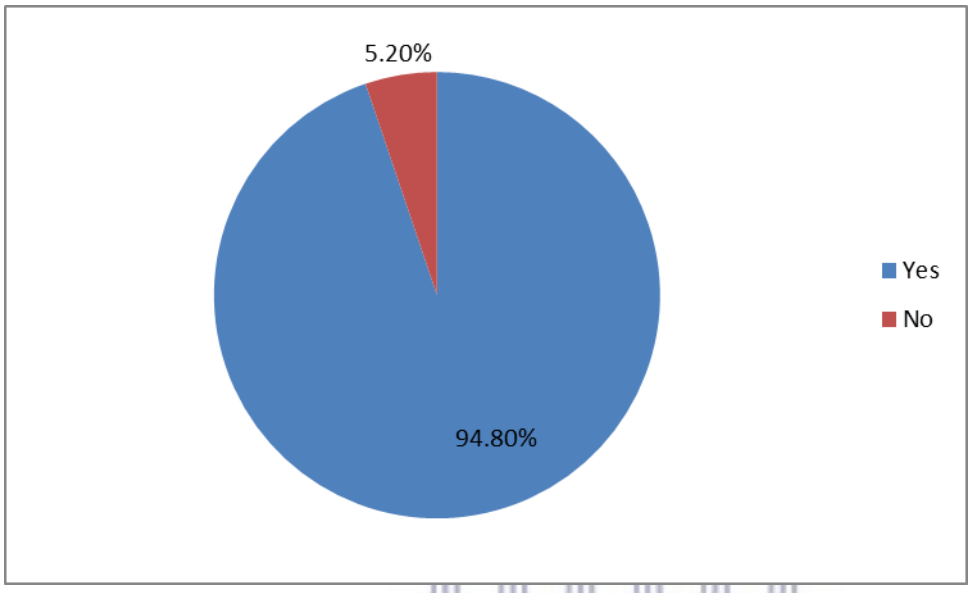


Figure 4: Participants' Belief Systems

4.5 Participants' spiritual and religious beliefs

Figure 5 presents the participants' spiritual and religious beliefs, one hundred and nine participants (37.2%) considered themselves to be both spiritual and religious where as 25.9%, participants (n=108) considered themselves as spiritual only. The diagram illustrates how participants living with chronic illness view themselves with regards to being spiritual or religious within their lives.

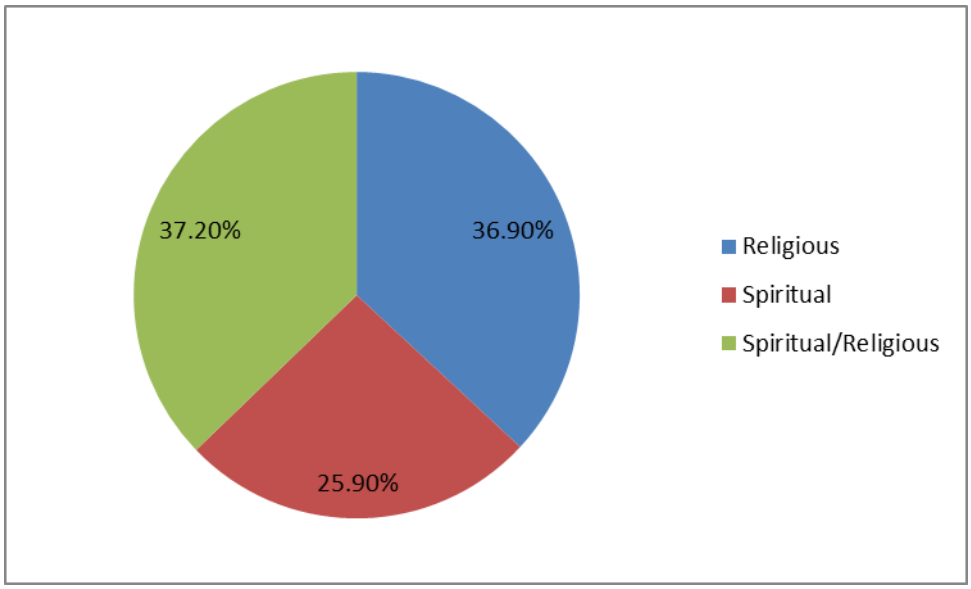


Figure 5: Participants' Spiritual and Religious Beliefs

4.6 Spiritual Needs

4.6.1 Religious dimension

In relation to persons living with chronic illness and religious spiritual needs, thirty percent of the participants (n=94, 30.7%) were in strong agreement that someone of their religious community (i.e. pastor) cares for them. Slightly, over ten percent of the participants (n=41, 13.4%) were somewhat in agreement that someone of their religious community (i.e. pastor) cares for you. A little less than sixty percent of the participants (n=176, 57.5%) reported very strong in agreement to be forgive, whereas a minority of the sample (n= 22, 7.2%) reported somewhat in agreement to be forgiven. Five percent of the participants (n=18, 5.9%) reported somewhat in agreement to pray with someone, whereas slightly less than sixty percent of the participants (n=175, 57.2%) reported very strong in agreement to pray with someone. A very small percentage of the participants (n= 9, 2.9%) reported somewhat in agreement that someone prays for you, whereas sixty percent of the participants (n=186, 60.8%) reported very strong in agreement that someone prays for you. Half of the population sample (n=160,

52.3%) reported very strong in agreement to participate at religious ceremony (i.e. service), whereas less than ten percent of the sample (n=24, 7.8%) reported somewhat in agreement to participate at religious ceremony (i.e. service). A little less than half of the population sample (n=144, 47.1%) reported very strong in agreement to read religious/spiritual books, whereas less than ten percent of the population sample (n=28, 9.2%) reported somewhat in agreement to read religious/spiritual books. A small percentage of the participants (n=17, 5.6) reported somewhat in agreement to turn to a higher presence (i.e. God, Allah, Angels, Oneness), whereas a larger portion of the participants (n=213, 69.6%) reported very strong in agreement to turn to a higher presence (i.e. God, Allah, Angels, Oneness).

Table 3 below illustrates the mean scores of religious spiritual needs. The highest mean scores were from participants who indicated *to turn to a higher presence (i.e. God, Allah, Angels, Oneness)* (M= 2.68, SD=0.58) as well as *that someone prays for you* (M= 2.63, SD=0.54). The lowest scores were from participants who indicated *that someone of their religious community (i.e. pastor) cares for them* (M= 2.25, SD=0.73).

Table 3: Religious dimensions

During the last time, did you have the needs		If YES How strong is this need?				
		somewhat	**Strong**	**Very strong**	*M*	*SD*
N3	That someone of your religious community (i.e. pastor) cares for you?	13.4%	30.7%	32.4%	2.25	0.73
N18	To be forgiven?	7.2%	29.1%	57.5%	2.45	0.63
N19	To pray with someone?	5.9%	29.7%	27.2%	2.55	0.61
N20	That someone prays for you?	2.9%	28.8%	60.8%	2.63	0.54
N21	To participate at a religious ceremony (i.e. service)?	7.8%	27.5%	52.3%	2.51	0.65
N22	To read religious / spiritual books?	9.2%	30.4%	47.1%	2.44	0.67
N23	To turn to a higher presence (i.e. God, Allah, Angels, Oneness)?	5.6%	19.6%	69.6%	2.68	0.58

4.6.2 Inner Peace dimension

In relation with inner peace, spiritual needs of an individual's living with chronic illness, a little less than thirty percent of the participants (n=89, 29.1) were very strong in agreement to talk to others about their fears and worries. A small percentage of the participants (n=48, 15.7%) were somewhat in agreement to talk to others about their fears and worries. A little less than forty percent of the participants (n=116, 37.9%) were very strong in agreement to plunge in the beauty of nature, whereas a little over fifteen percent of the participants (19, 16.0%) were somewhat in agreement to plunge in the beauty of nature. Slightly, over forty percent of the participants (n=135, 44.1%) were very strong in agreement to dwell at a place of quietness and peace, whereas less than fifteen percent of the participants (n=44, 14.4%) were somewhat agreement to dwell at a place of quietness and peace. Under ten percent of the sample (20, 6.5%) were somewhat in agreement to find inner peace, however a little over forty percent of the sample (134, 43.8%) were very strong in agreement to find inner peace.

Slightly over five percent of the participants (n=22, 7.2%) were somewhat in agreement to turn to someone in a loving attitude, whereas under forty percent of the participants (n=115, 37.6%) were very strong in agreement to turn to someone in a loving attitude.

Table 4 below illustrates the mean scores of inner peace. The highest mean scores were from participants who indicated *to find inner peace* (M= 2.42, SD=0.62). The lowest scores were from participants who indicated *to talk with others about your fears and worries* (M= 2.18, SD=0.76).

Table 4: Inner peace dimension

During the last time, did you have the needs		**If YES** **How strong is this need?**				
		somewhat	**strong**	**Very strong**	*M*	*SD*
N2	To talk with others about your fears and worries?	15.7%	28.8%	29.1%	2.18	0.76
N6	To plunge into beauty of nature?	16.0%	31.0%	37.9%	2.26	0.75
N7	To dwell at a place of quietness and peace?	14.4%	31.0%	44.1%	2.33	0.73
N8	To find inner peace?	6.5%	40.5%	43.8%	2.42	0.62
N13	To turn to someone in a loving attitude?	7.2%	30.7%	37.6%	2.40	0.65

4.6.3 Existential (Reflection/Meaning) dimension

In relation with existential (reflection/meaning) spiritual needs, a third of the sample (n=103, 33.7%) were in strong agreement to reflect on their previous life, whereas less than ten percent of the sample (n=24, 7.8) were somewhat in agreement to reflect on their previous life. Less than half of the participants (n=129, 42.2%) were strong in agreement to dissolve open aspects of your life, whereas less than ten percent of the participants (n=26, 8.5%) were

somewhat in agreement to dissolve open aspects of your life. To find meaning in illness and/or suffering ten percent of the participants (n= 36, 11.8%) were somewhat in agreement, whereas thirty percent of the participants (n=96, 31.4%) were very strong in agreement to find meaning in illness and/or suffering. Less than ten percent of the participants (n=24, 7.8%) were somewhat in agreement to talk to someone about the question of meaning of life, however thirty percent of the participants (n=92, 30.1%) were very strong in agreement to talk to someone about the question of meaning of life. Slightly less than a third of the sample (n=83, 27.1%) were very strong in agreement to talk to someone about the possibility of life after death, whereas less than ten percent of the sample (n=28, 9.2%) were somewhat in agreement to talk to someone about the possibility of life after death. Half of the population sample (n=160, 52.3%) reported very strong in agreement to forgive someone from a distinct period of their life, whereas less than ten percent of the sample (n=22, 7.2%) reported somewhat in agreement to forgive someone from a distinct period of their life.

Table 5 below illustrates the mean scores of existential (reflection/meaning) spiritual needs. The highest mean scores were from participants who indicated *to forgive someone from a distinct period of your life* (M= 2.49, SD=0.64). The lowest scores were from participants who indicated *to dissolve open aspects of your life* (M= 2.21, SD=0.64).

Table 5: Existential (meaning/Reflection) dimension

During the last time, did you have the needs		If YES How strong is this need?				
		somewhat	**strong**	**Very strong**	*M*	*SD*
N4	To reflect your previous life?	7.8%	33.7%	29.1%	2.30	0.65
N5	To dissolve open aspects of your life?	8.5%	42.2	24.5%	2.21	0.62
N10	To find meaning in illness and/or suffering?	11.8%	30.7%	31.4%	2.27	0.71
N11	To talk with someone about the question of meaning in life?	7.8%	28.8%	30.1%	2.33	0.67
N12	To talk with someone about the possibility of life after death?	9.2%	26.5%	27.1%	2.29	0.70
N16	To forgive someone from a distinct period of your life?	7.2%	31.7%	52.3%	2.49	0.64

4.6.4 Actively Giving / Generativity

In relation with actively giving / generativity spiritual needs, a little over five percent of the participants (n=21, 6.9%) were somewhat in agreement to solace someone, whereas slightly over forty-five percent of the participants (n=141, 46.1%) were very strong in agreement to solace someone. Half of the population sample (n=166, 54.2%) reported very strong in agreement to pass life experiences to others, whereas a small percentage of the population sample (n=20, 6.5%) reported somewhat in agreement to pass own life experiences to others. A minute percent of the participants (n=15, 4.9%) reported somewhat in agreement to be assured that your life was meaningful and of value, whereas slightly more than half of the participants (n=173, 56.5%) reported very strong in agreement to be assured that your life was meaningful and of value.

Table 6 below illustrates the mean scores of actively giving / generativity spiritual needs. The highest mean scores were from participants who indicated *to be assured that your life was*

meaningful and of value (M= 2.56, SD=0.59). The lowest scores were from participants who indicated *to solace someone* (M= 2.45, SD=0.63).

Table 6: Actively Giving/ Generativity dimension

During the last time, did you have the needs		**If YES** **How strong is this need?**				
		somewhat	**strong**	**Very strong**	*M*	*SD*
N15	To solace someone?	6.9%	34.0%	46.1%	2.45	0.63
N26	To pass own life experiences to others?	6.5%	28.4%	54.2%	2.53	0.63
N27	To be assured that your life was meaningful and of value?	4.9%	30.7%	56.5%	2.56	0.59

4.6.5 Additional Spiritual Needs Concerns

Less than half of the sample size (n=131, 42.8%) were very strong in agreement to give away from themselves, whereas around ten percent of the participants (n=35, 11.4%) were somewhat in agreement to give away something from themselves. A very small proportion of the population sample (n=11,3.6%) reported somewhat in agreement for being complete and safe, whereas a little less than sixty prevent of the population sample (n= 176,57.5%) reported very strong in agreement for being complete and safe. Sixty percent of the population sample (n= 195, 63.7%) reported very strong in agreement to feel connected with family, whereas a minute percentage of the population sample (n=13, 42%) reported somewhat in agreement to feel connected with family. A little less than fifty percent of the participants (n=151, 49.3%) reported very strong in agreement to be re-involved by your family in their life concerns, whereas less than ten percent of the participants (n=25, 8.2%) reported somewhat in agreement to be re-involved by your family in their life concerns. A minute percentage of the participants (n=9, 2.9%) reported somewhat in agreement to receive more support

from your family, whereas around sixty percent of the participants (n=191, 62.4%) reported very strong in agreement to receive more support from your family.

Table 7 below illustrates the mean scores Additional spiritual needs concerns. The highest mean scores were from participants who indicated *to receive more support from your family* (M= 2.65, SD=0.54). The lowest scores were from participants who indicated *to give away something from yourself* (M= 2.39, SD=0.672).

Table 7: Additional spiritual needs Concerns

During the last time, did you have the needs		**If YES** **How strong is this need?**				
		somewhat strong		**Very strong**	*M*	*SD*
N14	To give away something from yourself?	11.4%	25.8%	42.8%	2.39	0.72
N24	For being complete and safe?	3.6%	35.6%	57.5%	2.56	0.56
N25	To feel connected with family?	4.2%	25.5%	63.7%	2.64	0.56
N28	To be re-involved by your family in their life concerns?	8.2%	30.4%	49.3%	2.47	0.66
N30	To receive more support from your family?	2.9%	26.1%	62.4%	2.65	0.54

4.7 Health related quality of life of the participants living with chronic diseases.

4.7.1 Physical well-being

In relation to physical well-being with persons living with chronic illness, thirty percent (n=88, 30%) of the participants felt that they had somewhat lack of energy, however, less than fifteen percent reflected that it didn't impact their energy levels (n=38, 12.4 %). Furthermore, majority of the participants indicated that they did not experience nausea (n=174, 56.9%) compared to just over five percent who indicated they experienced nausea (n=16, 19%). Pain has been reported by the participants (n=144, 47, 1%) as a major influence on their physical well-being. A small minority of participants (n=55, 18.0%) reported that pain did not have a significance on their physical health and wellbeing. Less than half of the sample (n=147,47.4%) size reported that they were not at all bothered with the side effects of treatment where as just a little less than ten percent of the participants (n=27,8.8%) were somewhat bothered about the side effects of the treatment. Participants who reported to feel ill within the study was just a little under twenty percent (n=60, 19.6%) however participants who indicated that they did not at all feel sick was a little over thirty percent (n=98, 32.0%). A third of the participants (n=114, 37.3%) indicated that they were not at all forced to spend time in bed, compared to twenty percent of the sample (n=64, 20.9%) that reported that they were very much forced to spend time in bed. Participants (n=86, 28.1%) reported that because of my physical condition, they have trouble somewhat meeting the needs of their family compared to the 20 percent of the participants (n= 67, 21.9%) that indicated because of my physical condition, they did not at all have trouble meeting the needs of their family. Table 8 below illustrates the mean scores of physical wellbeing.

Table 8: Physical Well-being

No	Physical well-being	Not at all	A little bit	somewhat	Quite a bit	Very much
GP1	I have a lack of energy	12.4%	23.2%	28.8%	16.7%	19.0%
GP2	I have nausea	56.9%	9.5%	19.6%	7.8%	6.2%
GP3	Because of my physical condition, I have trouble meeting the needs of my family	21.9%	12.7%	28.1%	17.0%	20.3%
GP4	I have pain	18.0%	5.6%	10.8%	18.6%	47.1%
GP5	I am bothered by side effects of treatment	47.4%	16.7%	8.8%	17.0%	9.8%
GP6	I feel ill	32.0%	12.1%	17.6%	19.6%	18.6%
GP7	I am forced to spend time in bed	37.3%	7.8%	21.2%	12.7%	20.9%

Table 9 below presents the highest mean scores were from participants who indicated *I have pain* (M= 2.71, SD=1.53). The lowest scores were from participants who indicated *l have nausea* (M= 0.97, SD=1.28).

Table 9: Mean and Standard of Physical well-being

No	Items	*M*	*SD*
GP1	I have a lack of energy	2.07	1.28
GP2	I have nausea	0.97	1.28
GP3	Because of my physical condition, I have trouble meeting the needs of my family	2.01	1.41
GP4	I have pain	2.71	1.53
GP5	I am bothered by side effects of treatment	1.25	1.44
GP6	I feel ill	1.81	1.52
GP7	I am forced to spend time in bed	1.72	1.57

4.7.2 Social and Family Well-being

In relation with social and family well-being, participants (n= 1147, 38.2%) with chronic illness reported that they did not at all feel close to their friends, where as 30 percent of the sample (n=104, 34.0%) reported that they felt very much close to their friends. More so, a little less than 50 percent of the sample (n=150, 49.0%) reported that they very much get emotional support from their family, however, 20 percent of the participants (n=93, 30.4%) viewed that they did not at all get emotional support from family. Less than a third of the participants (n=93, 30.4%) indicated that they very much get support from their friends, however, a little over 40 percent (n=129, 42.2%) illustrated that they did not at all get emotional support from their friends. Majority of the participants (n=192, 62.7%) viewed that their family very much accepted their illness, where as a small percentage of participants (n=28, 9.2%) indicated that their family did not at all accept their illness. A very small percentage of the participants (n=17, 5.6%) somewhat felt satisfied with family communication about their illness. However, just under fifty percent of the sample (n=151, 49.3%) reported to feel very much satisfied with their family communication about their illness. Sixty percent of the participants (n=192, 62.7%) reported to very much feeling close to their partner, however a very small percentage of participants (n=14, 4.6%) indicated to feel a little bit or somewhat close to their partner (n=14, 4.6%). A quarter of the participants (n=80, 26.1%) reported to not at all feeling satisfied with their sex life, whereas twenty percent of the sample (n=64, 20.9%) illustrated that they feel very much satisfied with their sex life. Table 10 below presents the frequencies of social and family well-being.

Table 10: Social and family well-being

No	Social and family well-being	Not at all	A little bit	somewhat	Quite a bit	Very much
GS1	I feel close to my friends	38.2%	14.4%	6.5%	6.9%	34.0%
GS2	I get emotional support from my family	21.2%	8.2%	10.5%	11.1%	49.0%
GS3	I get support from my friends	42.2%	8.5%	10.5%	8.5%	30.4%
GS4	My family has accepted my illness	9.2%	6.5%	6.9%	14.4%	62.7%
GS5	I am satisfied with family communication about my illness	15.4%	8.5%	5.6%	20.9%	49.3%
GS6	I feel close to my partner (or the person who is my main support)	18.6%	4.6%	4.6%	9.5%	62.7%
GS7	I am satisfied with my sex life	26.1%	6.5%	6.5%	11.4%	20.9%

Table 11 below illustrates the mean scores of social/family wellbeing. The highest mean scores were from participants who indicated *my family has accepted my illness* (M= 3.15, SD=1.33) as well as I feel close to my partner (or the person who is my main support) (M= 2.93, SD=1.59). The lowest scores were from participants who indicated *I get support from my friends* (M= 1.76, SD=1.74)

Table 11: Mean and standard deviation of the subscales of social/family well-being

No	Items	*M*	*SD*
GS1	I feel close to my friends	1.84	1.75
GS2	I get emotional support from my family	2.53	1.63
GS3	I get support from my friends	1.76	1.74
GS4	My family has accepted my illness	3.15	1.33
GS5	I am satisfied with family communication about my illness	2.81	1.50
GS6	I feel close to my partner (or the person who is my main support)	2.93	1.59
GS7	I am satisfied with my sex life	1.92	1.70

4.7.3 Emotional Well-being

In relation with Emotional well-being and persons with chronic illness, just a little under 40 percent of the participants (n=118, 38.6%) did not at all feel sad, however a small percentage of the participants (n=55, 18.0%) felt very much sad. A third of the participants (n=101, 33.0%) indicated that they were very much satisfied with how they were coping with their illness, whereas less than twenty percent of the sample (n=49, 16. %) reported to not at all feeling satisfied with how they were coping with their illness. A little over fifty percent of the participants (n=166, 54.2%) reported to not at all losing hope in the fight against their illness, whereas less than twenty percent of the participants (n=50, 16.3%) indicated that they were very much losing hope in the fight against their illness. Thirty percent of the participants (n= 94, 30.7%) reported to not at all feeling nervous, however less than twenty percent of the participants (n=56, 18.3%) reported feeling very much nervous. Half of the participants (n=157, 51.3%) reported to not at all feel worry about dying, however a quarter of the participants (n=82, 26.8%) indicated to feeling very much worry about dying. A third of the participants (n=104, 34. %) reported to be very much worried that their condition will get

worse, whereas 10 percent illustrated of the participants (n=32, 10.5%) were a little worried that their condition will get worse. Table 12 presents the frequencies of emotional well-being.

Table 12: Emotional well-being

Emotional well-being	Not at all	A little bit	somewhat	Quite a bit	Very much
I feel sad	38.6%	9.2%	22.5%	11.8%	18.0%
I am satisfied with how I am coping with my illness	16.0%	10.5%	11.8%	28.8%	33.0%
I am losing hope in the fight against my illness	54.2%	9.2%	10.5%	9.8%	16.3%
I feel nervous	30.7%	14.1%	25.2%	11.8%	18.3%
I worry about dying	51.3%	8.8%	6.9%	6.2%	26.8%
I worry that my condition will get worse	27.8%	10.5%	11.8%	16.0%	34.0%

Table 13 below illustrates the mean scores of emotional wellbeing. The highest mean scores were from participants who indicated: I am satisfied with how I am coping with my illness (M= 2.52, SD=1.44) and I worrying that my condition will get worse (M= 2.18, SD=1.64). The lowest scores were from participants who indicated I am losing hope in the fight against my illness (M= 1.25, SD=1.56).

Table 13: Mean and standard deviation emotional well-being

Emotional well-being	Mean	Standard deviation
I feel sad	1.61	1.52
I am satisfied with how I am coping with my illness	2.52	1.44
I am losing hope in the fight against my illness	1.25	1.56
I feel nervous	1.73	1.46
I worry about dying	1.48	1.73
I worry that my condition will get worse	2.18	1.64

4.7.4 Functional Well-being

In relation with Functional well-being and persons with chronic illness, a little under thirty percent of the participants (n=90, 29.4) viewed they were somewhat able to do some paid work (include work at home), whereas twenty percent of the participants (n=66, 21.6%) indicated that they were very much able to work (include work at home). Ten percent of the participants (n=37, 12.1%) reported to not at all feel their work (include work at home) if fulfilling, however, a quarter of the sample (n=82, 26.1%) reported to feeling quite a bit that their work (include work at home) is fulfilling. Less than half of the participants (N=127, 41.5%) reported that they were very much able to enjoy life, whereas a little over ten percent of the participants (n= 42, 13.7%) reported that they were not at all able to enjoy life. Slightly over half of the sample (n=168, 54.9%) indicated to very much have accepted their illness, however ten percent of the sample (n=33, 10.8%) reported to not at all have accepted their illness. Almost forty percent of the participants (n=115, 37.6%) reported sleeping well a little bit, whereas thirty percent of the participants (n=99, 32.4%) reported to very much sleeping well. Thirty five percent of the participants (n=107, 35.0%) reported to not at all enjoying the things they usually do for fun, whereas a little over forty percent of the participants (n=76, 24.8%) indicated that they very much are enjoying the thing they usually do for fun. Thirty

five percent of the participants (n=108, 35.3%) reported to very much feeling content with the quality of their life right now, whereas a quarter of the participants (n=82, 26.8%) reported to not at all feeling content with the quality of their life right now. Table 14 presents the frequencies of functional well-being.

Table 14: Functional well-being

No	Functional well-being	Not at all	A little bit	somewhat	Quite a bit	Very much
GF1	I am able to work (include work at home)	10.5%	20.6%	29.4%	18.0%	21.6%
GF2	My work (include work at home) is fulfilling	12.1%	17.0%	18.0%	26.8%	26.1%
GF3	I am able to enjoy life	13.7%	13.4%	17.6%	13.7%	41.5%
GF4	I have accepted my illness	10.8%	10.5%	6.5%	17.0%	54.9%
GF5	I am sleeping well	13.1%	37.6%	11.4%	5.6%	32.4%
GF6	I am enjoying the things I usually do for fun	35.0%	13.4%	14.7%	12.1%	24.8%
GF7	I am content with the quality of my life right now	26.8%	8.8%	11.4%	17.3%	35.3%

Table 15 below illustrates the mean scores of functional wellbeing. The highest mean scores were from participants *who I have accepted my illness* (M= 2.95, SD=1.41) as well as I am able to enjoy life (M= 2.56, SD=1.47). The lowest scores were from participants who indicated *I am enjoying the things I usually do for fun* (M= 1.78, SD=1.61).

Table 15: Mean and standard deviation of the subscales of functional well-being

No	Items	*M*	*SD*
GF1	I am able to work (include work at home)	2.20	1.27
GF2	My work (include work at home) is fulfilling	2.38	1.35
GF3	I am able to enjoy life	2.56	1.47
GF4	I have accepted my illness	2.95	1.41
GF5	I am sleeping well	2.07	1.50
GF6	I am enjoying the things I usually do for fun	1.78	1.61
GF7	I am content with the quality of my life right now	2.26	1.64

4.7.5 Additional concerns of quality of life

In relation to additional concerns with persons with chronic illness, around forty percent of the participants (n=133, 43.5%) felt at peaceful, whereas ten percent of the participants (n=31, 10.1%) reported to feeling a little bit peaceful. Majority of the participants (n=236, 77.1%) reported to having very much a reason for living, however just less than five percent of the participants (n=15, 4.9%) reported not at all to have a reason for living. Around thirty percent of the participants (n=97, 31.7%) very much feel their life has been productive, whereas ten percent of the participants (n=30, 9.8%) reported to not at all feel their life has been productive. Thirty percent of the participants (n=100, 32.7%) reported that they were somewhat have trouble feeling peace of mind, however, twenty percent of the participants (n=73, 23.9%) reported to not at all have trouble feeling peace of mind. A little less than forty percent of the participants (n=115, 37.6%) indicated to very much feel a sense of purpose in their life, whereas slightly less than ten percent of the participants (n=25, 8.2%) reported to feeling a sense of purpose a little bit. Almost half of the sample (n=143, 46.7%) reported to very much being able to reach down deep into their self for comfort, however, less than ten percent of the sample (n=25, 8.2%) reported not at all able to reach down deep into their self

for comfort. A little less than forty percent of the sample (n=118, 38.6%) illustrated to very much feeling a sense of harmony within their self, however a little under fifteen percent of the sample (n=45, 14.7%) felt a sense of harmony within themselves a little bit. A little less than fifty percent of the participants (n=144, 47.1%) reported to not at all that their life lacks meaning and purpose, whereas thirteen percent of the participants (n=40, 13.1%) reported that their life lacks meaning and purpose very much. Large portion of the sample (n=223, 72.9%) reported to very much finding comfort in their faith or spiritual beliefs, whereas less than five percent of the sample (n=11, 3.6%) reported to not at all finding comfort in their faith or spiritual beliefs.

Majority of the participants (n=214, 69.9%) reported to very much finding strength in their faith or spiritual beliefs, however less than five percent of the participants (n= 14, 4.6%) reported to not at all finding strength in their faith or spiritual beliefs. Sixty percent of the participants (n=192, 62.7%) reported that their illness has strengthened their faith or spiritual beliefs. However, less than ten percent of the participants (n=21, 6.9%) reported that not at all that their illness has strengthened their faith or spiritual beliefs. slightly above five percent of the participants (n=20, 6.5%) indicated not at all to feeling that they know whatever happens with their illness, things will be okay. In addition, sixty percent of the sample (n=187, 61.1%) reported to feeling very much that they know whatever happens with their illness, things will be okay. Table 16 below presents the frequencies of additional concerns of quality of life.

Table 16: Additional concern of quality of life

No	Additional Concerns	Not at all	A little bit	somewhat	Quite a bit	Very much
Sp1	I feel peaceful	13.1%	10.1%	14.4%	19.0%	43.5%
Sp2	I have a reason for living	4.9%	3.3%	3.6%	11.1%	77.1%
Sp3	My life has been productive	9.8%	13.4%	18.0%	26.8%	31.7%
Sp4	I have trouble feeling peace of mind	23.9%	9.5%	32.7%	17.0 %	17.0%
Sp5	I feel a sense of purpose in my life	12.4%	8.2%	11.8%	30.1%	37.6%
Sp6	I am able to reach down deep into myself for comfort	8.2%	5.9%	8.5%	30.7%	46.7%
Sp7	I feel a sense of harmony within myself	8.8%	14.7%	10.5%%	27.5%	38.6%
Sp8	My life lacks meaning and purpose	47.1%	15.4%	7.8%	16.3%	13.1%
Sp9	I find comfort in my faith or spiritual beliefs	3.6%	5.2%	5.6%	12.7%	72.9%
Sp10	I find strength in my faith or spiritual beliefs	4.6%	4.9%	7.2%	13.4%	69.9%
Sp11	My illness has strengthened my faith or spiritual beliefs	6.9%	6.2%	7.2%	17.0%	62.7%
Sp12	I know that whatever happens with my illness, things will be okay	6.5%	3.9%	8.2%	20.3%	61.1%

Table 17 below illustrates the mean scores of additional concerns of quality of life wellbeing. The highest mean scores were from participants who indicated *I have a reason for living* (M= 3.52, SD=1.05) as well as *I find comfort in my faith or spiritual beliefs* (M= 3.46, SD=1.05) and I find strength in my faith or spiritual beliefs (*M*=3.39, *S*=1.10). The lowest scores were from participants who indicated *my life lacks meaning and purpose* (M= 1.33, SD=1.51).

Table 17: Mean an standard deviation of the subscales of Additional concerns of quality of life

No	Items	*M*	*SD*
Sp1	I feel peaceful	2.70	1.44
Sp2	I have a reason for living	3.52	1.05
Sp3	My life has been productive	2.57	1.32
Sp4	I have trouble feeling peace of mind	1.94	1.37
Sp5	I feel a sense of purpose in my life	2.72	1.36
Sp6	I am able to reach down deep into myself for comfort	3.02	1.23
Sp7	I feel a sense of harmony within myself	2.72	1.34
Sp8	My life lacks meaning and purpose	1.33	1.51
Sp9	I find comfort in my faith or spiritual beliefs	3.46	1.05
Sp10	I find strength in my faith or spiritual beliefs	3.39	1.10
Sp11	My illness has strengthened my faith or spiritual beliefs	3.23	1.23
Sp12	I know that whatever happens with my illness, things will be okay	3.25	1.17

4.8 Occupational balance

This section focuses on results related to occupational balance of the participants living with chronic diseases. The percentages and frequencies are presented according to the participants' responses concerning occupational balance.

Table 18: Frequencies in everyday life under-demanding

Do you generally find your activities in your everyday life under-demanding?					
		Frequency	Percent	Valid Percent	Cumulative Percent
	I don't find my activities to be under-demanding	156	51.0	51.0	51.0
	I find some of my activities to be under-demanding	126	41.2	41.2	92.2
	I found most of my activities to be under-demanding	24	7.8	7.8	100.0
	Total	306	100.0	100.0	

Table 18 above presents that more than half of the participants (n= 156, 51.0%) reported that they did not find their activities to be under-demanding. However, there were participants (n=126, 41.2%) that found some of their activities under-demanding. A smaller number of the participants (n=24, 7.8%) found most of their activities to be under-demanding.

Table 19: Frequencies in everyday life over-demanding

Do you generally find your activities in your everyday life over-demanding?					
		Frequency	Percent	Valid Percent	Cumulative Percent
	I don't find my activities to be over-demanding	90	29.4	29.4	29.4
	I find some of my activities to be over-demanding	134	43.8	43.8	73.2
	I found most of my activities to be over-demanding	82	26.8	26.8	100.0
	Total	306	100.0	100.0	

Table 19 above presents that less than half of the participants (n=134, 43.8%) found some of their activities to be over-demanding. Whereas (n=82, 26.8%) participants found most of their activities were over-demanding.

Table 20: appreciation for activities in everyday life

Do you generally receive enough appreciation for activities in your everyday life?					
		Frequency	Percent	Valid Percent	Cumulative Percent
	I received quite a lot of appreciation	142	46.4	46.4	46.4
	I receive enough appreciation	110	35.9	35.9	82.4
	I do not receive any appreciation	54	17.6	17.6	100.0
	Total	306	100.0	100.0	

Table 20 above presents that with regards to receiving enough appreciation for engaging in activities of daily living, less than half of the participants (n=142, 46.4%) indicated that they do receive quite a lot of appreciation. Less than twenty percent of participants (n=54, 17.6%) reported that do not receive any appreciation.

Table 21: overstressed in everyday life

How often do you feel overstressed in your everyday life?					
		Frequency	Percent	Valid Percent	Cumulative Percent
	Never	21	6.9	6.9	6.9
	Sometimes	159	52.0	52.0	58.8
	Often	126	41.2	41.2	100.0
	Total	306	100.0	100.0	

Table 21 above presents that more than half of the participants (n=159, 52.0%) expressed that they sometimes felt overstressed. Although there were participants (n=126, 41.2) that indicated that they were often overstressed.

Table 22: activities in your everyday life affect by your health

How much are your activities in your everyday life affected by your health?					
		Frequency	Percent	Valid Percent	Cumulative Percent
	Not at all	33	10.8	10.8	10.8
	Little	139	45.4	45.4	56.2
	Very much	134	43.8	43.8	100.0
	Total	306	100.0	100.0	

Table 22 above presents that participants (n=139, 45.4%) indicated that their engagement in activities of daily living seemed to be little influenced by their health.

Table 23: Getting enough rest

Do you get enough rest?					
		Frequency	Percent	Valid Percent	Cumulative Percent
	I get enough rest	170	55.6	55.6	55.6
	I get little rest	86	28.1	28.1	83.7
	I get very little rest	50	16.3	16.3	100.0
	Total	306	100.0	100.0	

Table 23 above depicts that approximately more than half of the participants (n=170, 55.6%) indicated that they get enough rest. However, a little less than thirty percent of participants reported that they get little rest.

Table 24: Getting enough sleep

Do you get enough sleep?					
		Frequency	Percent	Valid Percent	Cumulative Percent
	I get enough sleep	126	41.2	41.2	41.2
	I get little sleep	96	31.4	31.4	72.5
	I get very little sleep	84	27.5	27.5	100.0
	Total	306	100.0	100.0	

In relation to sleep, Table 24 depicts that participants (n=126, 41.2%) reported that they get enough sleep. Whereas less than thirty percent of participants (n= 84, 27.5) indicated that they get very little sleep.

Table 25: Variety of different activities

Do you have sufficient variety of different activities that you do?					
		Frequency	Percent	Valid Percent	Cumulative Percent
	I have sufficient variety	93	30.4	30.4	30.4
	I have little variety	150	49.0	49.0	79.4
	I have no variety at all	63	20.6	20.6	100.0
	Total	306	100.0	100.0	

Table 25 above depicts that nearly fifty percent of participants reported that they have little variety of engaging in different activities. Around twenty percent of participants (n=63, 20.6%) indicated that they have no variety of engaging in different activities. The participants daily occupations were mainly activities that they do on a daily basis, thus they did not have a variety of activities.

Table 26: Adaptations of activities

How well can you adapt your activities in your everyday life to changed living conditions, such as a changed state of health					
		Frequency	Percent	Valid Percent	Cumulative Percent
	Very well	137	44.8	44.8	44.8
	Badly	140	45.8	45.8	90.5
	Not at all	29	9.5	9.5	100.0
	Total	306	100.0	100.0	

Table 26 above presents that approximately less than ten percent of participants (n=29, 9.5%) reported that they were unable to adapt to their activities in daily living in relation to the

changed state of health. Somewhat less than fifty percent of participants (n=140, 45.8) reported that they struggled to adapt to their activities in daily living in relation to the changed state of health.

Table 27: Adapt activities in your everyday life

How well can you adapt your activities in your everyday life to changed living conditions, such as a change of your professional life or employment status					
		Frequency	Percent	Valid Percent	Cumulative Percent
	Very well	83	27.1	27.2	27.2
	Badly	143	46.7	46.9	74.1
	Not at all	78	25.5	25.6	99.7
	4	1	.3	.3	100.0
	Total	305	99.7	100.0	
Missing	System	1	.3		
Total		306	100.0		

In relation to professional life or employment status, Table 27 above depicts that the participants (n=143, 46.7%) reported that they found it difficult to adapt their activities. Nearly thirty percent of the participants (n=83, 27.1%) reported to have adapted very well in changing their professional life or employment status.

Table 28 below illustrates the mean scores and standard deviations of occupational balance. The highest mean scores were from participants who indicated how often do you feel overstressed in your everyday life? (*M*= 2.34, *SD*=0.60) and how much are your activities in your everyday life affected by your health? (*M*= 2.34, *SD*=0.66). The lowest scores were from participants who indicated do you generally find your activities in your everyday life over-demanding (*M*= 1.57, *SD*=0.63).

Table 28: Mean and standard deviation of occupational balance

No	Items	*M*	*SD*
1	Do you generally find your activities in your everyday life under-demanding?	2.00	0.86
2	Do you generally find your activities in your everyday life over-demanding?	1.57	0.63
3	Do you generally receive enough appreciation for activities in your everyday life?	1.97	0.75
4	How often do you feel overstressed in your everyday life?	2.34	0.60
5	How much are your activities in your everyday life affected by your health?	2.34	0.66
6	Do you get enough rest?	1.61	0.75
7	Do you get enough sleep?	1.86	0.81
8	Do you have sufficient variety of different activities that you do? For example, do you do a mixture of physical activities and more sedentary ones	1.90	0.70
9	How well can you adapt your activities in your everyday life to changed living conditions, such as a changed state of health?	1.65	0.64
10	How well can you adapt your activities in your everyday life to changed living conditions, such as a change of your professional life or employment status?	1.99	0.73

4.9 Relationship between spirituality and health related quality of life

The relationships between religious spiritual needs and health related quality of life indicate that there were two significant negative relationships to be found between religious and physical wellbeing, I have a lack of energy (r = -.141*) and I have nausea (r = -.131*). In addition, four significant positive relationships were found between religious spiritual needs physical wellbeing, I have pain (r = .133*), bothered by the side effects of treatment (r = .184**), feeling ill (r = .169**), forced to spend time in bed (r = .139**).

The relationships between social wellbeing and religious spiritual needs indicate that there were four significant positive relationships to be found between religious and social/family wellbeing, I have pain (r =.138*), bothered by the side effects of treatment (r = .189*), feeling ill (r = .211 **) and bothered by the side effects of treatment (r =.218**).

The relationship between health related emotional well-being and religious spiritual needs thus indicate that there were two positive significant relationships found between religious and emotional well-being, I am satisfied with how I am coping with my illness (*r* =.224**), worrying about dying (*r* =.156*).

The relationships between religious spiritual needs and health related functional quality of life indicate that there were two significant negative relationships to be found between religious N22 and N23 in relation to functional wellbeing, I am sleeping well (*r* = -.134*) and (*r* = -.139*) respectively. In addition, there were four significant positives found to be with religious and functional well-being I am able to work (*r* = .186**), my work is fulfilling (*r* = .146*), I am able to enjoy life (*r* = .166**), I am enjoying the things I used to do for fun (*r* = .219**) and I am content with the quality of my life right now (*r* = .199**).

In relation to additional concerns and religious health related quality (*r* = -.134*) of life ten significant positive were found between additional concerns and spiritual religious needs I feel peaceful (*r* = .172**), (*r* = .132*) I have a reason for living (*r* = .126*) my life has been productive (*r* = .282**) I feel a sense of purpose in my life (*r* = .294**), I am able to reach down deep into myself for comfort (*r* = .294**), I feel a sense of harmony within myself (*r* = .306**), I find comfort in my faith or spiritual beliefs (*r* = .330**), I find strength in my faith or spiritual beliefs (*r* = .374**), my illness has strengthened my faith or spiritual beliefs (*r* = .336**) and I know that whatever happens with my illness , things will be okay (*r* = .304**).

There was a relationship between health related quality of life and spiritual needs inner peace. The result in the table reflect that there were four significant positives relationships found between spiritual inner peace and health related quality of life physical wellbeing , I have pain (*r* = .138*), I am bothered about side effects of treatment (*r* = .241**), I feel ill (*r* = .211**)

and I am forced to spend time in bed (r = .218**). In addition, there were two significant positive relationships found between spiritual inner peace and health related quality of life (social/family wellbeing), my family has accepted my illness (r = .158**) and I am satisfied with family communication about my illness (r = .171**). One negative significant positive relationship were indicated as well between spiritual inner peace and health related quality of life (social/family wellbeing), I feel close to my partner (r = -.136*). There were two significant positive relationships found spiritual inner peace and health related quality of life (emotional wellbeing), I am losing hope in the fight against my illness(r = .126*) and I worry about dying (r = .169**). Results indicate there were four significant positive relationships found between spiritual inner peace and health related quality of life functional wellbeing I am able to work, (r = .163**), my work is fulfilling, (r = .135*), I am enjoying the things I usually do for fun (r = .165*) and I am content with the quality of my life right now, (r = .150*). With additional concerns, 10 significant positive relationships were found between spiritual inner peace and additional concerns health related quality of health, I feel peaceful (r = .119*), my life has been productive (r = .208**), I feel a sense of purpose (r = .312**), I am able to reach down deep into myself for comfort (r = .310**), I feel a sense of harmony within myself (r = .357**), my life lacks meaning and purpose (r = .138*), I find comfort in my faith or spiritual beliefs (r = .260**), I find strength in my faith or spiritual beliefs (r = .224**), my illness has strengthened my faith or spiritual beliefs (r = .329**) and I know that whatever happens with my illness things will be okay (r = .321**).

Within the relationships between health related quality of life and existential spiritual needs three negative significant relationships were found between physical wellbeing and existential spiritual needs, I have a lack of energy (r = -.199**), I have nausea (r = -.209**) and because of my physical condition, I have trouble meeting the needs of my family (r = -.140*). In

addition, four significant positive relationships were found between physical wellbeing and existential spiritual needs, I have pain (*r* = .167*), I am bothered by side effects of treatment (*r* = .182**), I feel ill (*r* = .173**) and I am forced to spend time in bed (*r* = .227**). One significant positive relationship was found between social wellbeing and existential spiritual needs, I am satisfied with family communication about my illness (*r* = .169**). There was one significant negative relationships found between emotional wellbeing and existential spiritual needs I feel sad (*r* = -.172*). In addition, three significant positive relationships were found between emotional wellbeing and existential spiritual needs, I am satisfied with how I am coping with my illness (*r* = .145*), I am losing hope in the fight against my illness (*r* = .228**) and I worry that my condition will get worse (*r* = .156*). There were three significant positive relationships found between functional wellbeing and existential spiritual needs, I am able to work (*r* = .138*), I am enjoying the things I usually do for fun (r = .148*), I am content with the quality of my life right now (*r* = .253**). Eleven significant positive relationships were found between additional concerns of health related quality of life and existential spiritual needs. I feel peace (r = .141*), I have a reason for living (r = .131*), my life has been productive (r = .319**), I have trouble feeling peace of mind (r = .194**), I feel a sense of purpose in my life (r = .289**), I am able to reach down deep into myself for comfort (r = .351**), I feel a sense of harmony within myself (r = .348**), I find comfort in my faith or spiritual beliefs (r = .347**), I find strength in my faith or spiritual beliefs (r = .283**), my illness has strengthened my faith or spiritual beliefs (r = .317**) and I know that whatever happens with my illness, things will be okay (r = .329**).

Within the relationships between health related quality of life and actively giving and spiritual needs, three significant positive relationships were found between physical wellbeing and actively giving spiritual needs, I am bothered by side effects of treatment *(r* = .176**), I feel ill *(r* = .128*) and I am forced to spend time in bed *(r* = .150*). Three significant positive

relationship were found between social health related quality of life and actively giving spiritual needs, I feel close to my friends (r = .127*), I have pain (r = .121*) and I am bothered by side effects of treatment (r = .212**). In addition, two positive relationships were found between emotional health related quality of life and actively giving spiritual needs, I am satisfied with how I am coping with my illness *(r* = .158**) and I worry about dying *(r* = .161**). One significant positive relationship was found between functional health related quality of life and actively giving, I have accepted my illness *(r* = .162**), as well as one negative relationship were found between functional health related quality of life and actively giving I am sleeping well *(r* = -.197**). The result table thus indicate that there were eight significant positive relationships found between additional health related concerns and actively giving spiritual needs, my life has been productive *(r* = .209**), I feel a sense of purpose in my life *(r* = .322**), I am able to reach down deep into myself for comfort*(r* = .356**), I feel a sense of harmony within myself *(r* = .368**), I find comfort in my faith or spiritual beliefs *(r* = .265**), I find strength in my faith or spiritual beliefs *(r* = .280**), my illness has strengthened my faith or spiritual beliefs *(r* = -.306**) and I know that whatever happens with my illness, things will be okay *(r* = .350**).

Table 29: Relationship between spiritual needs and health-related quality of life

Correlations

		GP1	GP2	GP3	GP4	GP5	GP6	GP7	GS1	GS2	GS3	GS4	GS5	GS6	GS7	GE1	GE2	GE3	GE4	GE5	GE6	GF1	GF2	GF3	GF4	GF5	GF6	GF7	SP1	SP2	SP3	SP4	SP5	SP6	SP7	SP8	SP9	SP10	SP11	SP12
Spearman's rho	N2	-0.048	-0.056	-0.021	0.066	0.084	0.088	-0.001	0.044	-0.101	0.066	0.058	0.009	-0.072	-0.043	-0.071	-0.016	0.118	0.046	0.025	0.022	-0.066	-0.097	-0.032	-0.017	-0.075	-0.086	-0.026	0.024	0.007	0.018	-0.045	0.122	0.110	.171*	0.102	.149*	0.098	0.100	.154*
	N3	0.014	-0.079	0.092	-0.045	0.107	-0.002	-0.002	0.125	0.037	.148*	.166*	.171**	0.027	0.055	-0.128	.167*	0.030	-0.077	0.068	-0.045	0.102	.148*	0.060	0.043	0.071	.145*	.138*	.172**	.214**	.187**	0.081	.294**	.287**	.257**	0.104	.232**	.201**	.239**	.180**
	N4	-.199**	-.209**	-0.039	-0.063	0.087	-0.028	0.124	0.022	-0.020	0.082	0.105	0.043	-0.100	0.034	-.172*	.139*	.228**	0.120	.214**	0.126	0.071	-0.019	0.005	0.027	0.094	0.133	0.117	0.123	0.072	0.121	0.105	.232**	.351**	.348**	0.046	.293**	.192**	.223**	.236**
	N5	-.133*	-0.019	0.007	0.036	.182**	0.020	0.050	0.032	-0.116	0.067	0.045	0.095	-0.049	0.038	-0.101	.145*	.143*	-0.049	-0.011	0.067	.138*	0.107	0.111	0.067	0.063	.148*	.253**	.141*	.131*	.319**	0.002	.289**	.278**	.345**	0.044	.263**	.224**	.278**	.184**
	N6	-0.088	-0.077	-0.033	0.011	.189**	0.075	0.089	-0.055	-0.014	0.018	0.076	.138*	-0.080	0.009	-0.087	0.036	0.081	0.059	0.065	-0.014	.163*	.135*	0.118	0.042	0.043	.165**	0.086	0.098	-0.010	.269**	0.078	.312**	.256**	.283**	.138*	.190**	.178*	.154*	.168**
	N7	-0.023	0.019	-0.010	0.102	.241**	.211**	.218**	0.013	0.004	0.041	.158*	.171**	-0.093	-0.063	-0.006	0.063	.126*	0.072	.169**	0.110	0.074	-0.036	0.022	-0.002	-0.087	0.081	0.084	0.005	0.013	.124*	0.057	.217**	.243**	.237**	0.071	.194**	.172**	.247**	.208**
	N8	-0.053	-0.052	0.003	0.090	.154*	.172**	.191**	0.033	0.054	0.026	.137*	0.092	-0.090	0.110	-0.044	0.103	0.039	0.000	0.085	0.061	0.086	0.031	0.027	0.075	-0.057	.133*	.150*	.119*	0.077	.208**	0.059	.283**	.310**	.357**	-0.023	.260**	.224**	.329**	.258**
	N10	-0.063	0.020	-0.072	0.090	0.104	.173**	0.110	0.050	0.021	0.121	0.082	0.079	-0.005	-0.001	0.095	0.046	0.129	0.109	.140*	0.073	0.026	0.080	0.044	0.006	-0.068	0.063	0.019	-0.012	0.059	.167*	0.129	.165*	.162*	.181**	0.099	.186**	.160*	.227**	0.071
	N11	-0.072	-.154*	-.140*	0.129	0.044	.144*	0.077	-0.022	0.091	0.056	0.045	0.103	-0.017	-0.040	-0.056	0.051	-0.050	-0.009	0.051	-0.074	0.018	0.005	0.059	0.050	-0.011	0.086	.148*	0.031	0.087	.178*	0.104	.150*	.166*	.186**	0.086	.284**	.242**	.225**	.275**
	N12	0.031	-0.025	-0.061	.167*	0.053	.148*	.227**	-0.078	0.065	-0.015	0.047	0.077	-0.071	0.012	0.061	0.074	-0.015	-0.019	0.081	-0.013	0.005	0.009	0.045	0.079	-0.079	0.019	.148*	0.099	0.023	.182*	.194**	0.133	.283**	.274**	-0.009	.347**	.283**	.317**	.329**
	N13	-0.006	-0.043	-0.072	.138*	0.105	.147*	0.069	-0.123	-0.040	-0.055	0.002	0.098	-.136*	0.000	0.012	0.082	0.079	-0.003	0.086	0.010	0.068	0.011	-0.001	0.049	-0.082	-0.033	0.058	0.014	-0.021	.140*	0.090	0.115	.282**	.295**	0.013	.216**	.182**	.290**	.321**
	N14	-0.086	-0.113	0.071	0.056	.132*	.146*	.160*	-0.053	0.017	-0.030	0.090	.176**	-0.093	-0.026	-0.068	0.038	0.070	-0.053	0.046	0.088	0.006	0.008	-0.025	0.056	-0.077	-0.039	0.052	0.102	-0.001	0.107	0.054	.243**	.192**	.256**	-0.005	0.103	.133*	.273**	.242**
	N15	-0.030	-0.090	-0.022	0.078	0.062	0.040	0.068	0.014	-0.049	0.035	0.097	.165**	-0.023	-0.015	-0.117	0.060	0.012	0.029	0.099	0.093	0.058	0.108	0.017	.162**	-.129*	0.068	0.088	0.061	0.119	.209**	0.050	.228**	.294**	.361**	0.015	.258**	.259**	.306**	.264**
	N16	-0.072	-0.008	-0.039	0.033	0.052	0.070	0.037	0.080	-0.056	0.091	0.089	.169**	0.044	0.018	0.003	0.092	0.063	0.021	.124*	0.090	0.065	0.033	0.010	0.026	-0.112	0.084	0.063	0.055	0.059	.221**	0.062	.210**	.289**	.260**	-0.015	.194**	.246**	.258**	.243**
	N18	-.141*	-.131*	-0.108	-0.018	0.103	0.111	.139*	0.052	-0.005	.120*	0.052	.175**	-0.067	-0.008	-0.060	0.113	0.069	0.019	.156**	0.005	0.058	0.044	0.045	0.051	-0.083	.163**	0.104	0.098	.125*	.216**	0.045	.266**	.294**	.269**	-0.001	.249**	.273**	.295**	.304**
	N19	-0.100	-0.077	-0.116	-0.033	0.105	0.014	0.053	0.062	-0.056	0.056	0.050	.177**	-0.013	0.085	-0.010	0.113	0.003	-0.066	0.097	0.020	.155**	.146*	.166**	0.055	-0.053	.219**	.199**	.131*	0.067	.259**	0.037	.257**	.288**	.306**	0.016	.290**	.304**	.305**	.285**
	N20	-0.071	-0.093	-0.024	-0.061	0.113	0.054	0.039	0.051	0.013	0.082	.166*	.173**	-0.046	-0.014	0.010	.224**	0.047	0.018	0.113	0.073	.186*	.142*	.160**	0.100	-0.070	.203**	.168**	0.062	0.112	.217**	0.057	.275**	.225**	.289**	-0.023	.235**	.243**	.301**	.278**
	N21	-0.008	0.037	-0.033	0.014	0.090	0.086	.121*	.149*	-0.034	0.114	0.059	.183**	-0.050	0.018	0.071	.121*	0.028	-0.009	-0.007	0.023	0.049	0.089	.128*	0.079	-0.095	.201**	.190**	0.100	0.018	.282**	-0.004	.175*	.207**	.265**	-0.053	.330**	.337**	.335**	.146*
	N22	0.074	0.014	0.015	.133*	.184**	.169**	0.115	0.086	0.033	0.083	0.106	.187**	-0.034	0.115	0.016	.132*	-0.022	0.063	0.013	-0.002	.132*	0.062	0.087	0.103	-.134*	0.101	0.072	-0.015	0.126	.216**	0.013	.282**	.263**	.257**	-0.008	.295**	.329**	.336**	.282**
	N23	0.010	-0.065	-0.026	0.025	0.009	0.076	0.045	.163**	-0.059	.116*	-0.009	0.090	0.040	0.022	0.056	-0.008	-0.018	-0.003	0.066	0.079	0.014	0.011	-0.022	0.016	-.139*	0.041	0.032	0.018	0.052	.231**	0.033	.240**	.173**	.156**	0.013	.326**	.374**	.320**	.193**
	N24	-0.053	-0.105	-0.098	0.054	.142*	0.055	.123*	.132*	0.018	.138*	0.071	.138*	-0.071	-0.005	-0.045	.181**	0.012	0.054	.184**	0.113	0.076	0.024	0.003	0.091	-0.006	.152**	.137*	.122*	.123*	.252**	.134*	.265**	.267**	.324**	0.028	.276**	.306**	.392**	.333**
	N25	-0.024	-0.059	-0.011	0.031	0.019	0.037	0.038	0.099	0.031	0.087	.119*	.196**	-0.045	0.013	0.009	0.102	0.006	-0.029	0.077	0.079	0.080	0.078	0.018	0.032	-0.048	0.006	0.060	0.109	.138*	.195**	0.036	.220**	.280**	.157**	-0.051	.220**	.258**	.288**	.250**
		0.683	0.322	0.856	0.597	0.744	0.530	0.524	0.093	0.607	0.144	0.045	0.001	0.445	0.856	0.881	0.085	0.926	0.620	0.192	0.183	0.178	0.186	0.757	0.594	0.422	0.919	0.316	0.066	0.019	0.001	0.545	0.000	0.000	0.008	0.390	0.000	0.000	0.000	0.000
		286	286	286	286	285	286	286	286	286	286	285	285	286	209	286	286	286	286	286	286	286	286	286	285	286	286	285	286	286	285	286	286	286	286	285	286	286	286	286
	N26	0.058	0.017	0.017	0.118	0.090	0.107	0.060	.127*	0.023	0.088	0.117	.134*	-0.066	0.089	-0.002	0.099	0.012	0.024	.161**	0.066	0.030	0.023	0.049	0.116	-.142*	-0.010	0.078	-0.040	0.053	.159**	0.067	.322**	.228**	.207**	-0.042	.265**	.280**	.299**	.241**
		0.337	0.784	0.780	0.052	0.140	0.078	0.325	0.035	0.710	0.149	0.053	0.028	0.274	0.211	0.968	0.103	0.845	0.689	0.008	0.275	0.626	0.699	0.421	0.057	0.018	0.865	0.200	0.510	0.385	0.008	0.271	0.000	0.000	0.001	0.494	0.000	0.000	0.000	0.000
		273	273	273	273	272	273	273	273	273	273	272	272	273	198	273	273	273	273	273	273	273	273	273	272	273	273	272	273	273	272	273	273	273	273	272	273	273	273	273
	N27	-0.013	-0.015	-0.055	0.114	.176**	.128*	.150*	0.087	0.039	0.031	.121*	.212**	-0.072	0.045	-0.069	.158**	0.001	0.003	0.103	0.104	0.045	-0.020	0.020	0.109	-.197**	0.096	0.094	0.068	0.108	.178**	0.086	.208**	.356**	.368**	0.006	.251**	.259**	.272**	.350**
		0.825	0.800	0.354	0.056	0.003	0.032	0.011	0.147	0.511	0.603	0.043	0.000	0.228	0.525	0.245	0.008	0.993	0.966	0.085	0.080	0.454	0.738	0.735	0.067	0.001	0.109	0.117	0.254	0.069	0.003	0.150	0.000	0.000	0.000	0.918	0.000	0.000	0.000	0.000
		282	282	282	282	281	282	282	282	282	282	281	281	282	202	282	282	282	282	282	282	282	282	282	281	282	282	282	282	282	281	282	282	282	282	281	282	282	282	282
	N28	-0.061	-0.116	0.020	.122*	0.086	0.068	0.072	.121*	0.112	0.092	.281**	.340**	0.021	0.060	-0.097	.163**	0.012	-0.078	0.093	0.001	0.112	0.059	0.070	.135*	-0.069	.156**	.164**	.120*	.128*	.276**	0.039	.341**	.311**	.279**	0.022	.199**	.303**	.277**	.271**
		0.321	0.058	0.747	0.046	0.161	0.266	0.241	0.047	0.068	0.133	0.000	0.000	0.737	0.399	0.111	0.007	0.850	0.202	0.127	0.985	0.066	0.333	0.253	0.028	0.263	0.010	0.007	0.049	0.036	0.000	0.527	0.000	0.000	0.000	0.725	0.001	0.000	0.000	0.000
		269	269	269	269	268	269	269	269	269	269	268	268	269	197	269	269	269	269	269	269	269	269	269	268	269	269	268	269	269	268	269	269	269	269	268	269	269	269	269
	N30	-0.036	-.118*	0.039	0.030	0.100	0.111	0.045	0.023	0.032	0.049	0.045	.196**	-0.085	-0.104	-0.099	.139*	0.066	-0.033	0.082	0.040	0.071	0.029	0.042	0.026	-0.110	0.084	0.086	0.031	0.044	.243**	0.109	.212**	.249**	.176**	-0.003	.228**	.220**	.300**	.185**
		0.545	0.048	0.518	0.620	0.094	0.064	0.456	0.697	0.596	0.412	0.454	0.001	0.156	0.136	0.098	0.020	0.270	0.584	0.172	0.503	0.237	0.623	0.485	0.667	0.067	0.159	0.150	0.602	0.464	0.000	0.070	0.000	0.000	0.003	0.966	0.000	0.000	0.000	0.002
		280	280	280	280	279	280	280	280	280	280	279	279	280	205	280	280	280	280	280	280	280	280	280	279	280	280	279	280	280	279	280	280	280	280	279	280	280	280	280

**. Correlation is significant at the 0.01 level (2-tailed).

*. Correlation is significant at the 0.05 level (2-tailed).

Table 30: Relationship between spiritual needs and occupational balance

	1	2	3	4	5	6	7	8	9	10
To talk with others about your fears and worries	-0.054	-0.086	-0.009	0.064	-0.092	0.067	0.031	-0.064	-0.011	-0.026
That someone of your religious community (i.e. pastor) cares for you?	-0.054	-0.126	-.129*	-0.067	-.138*	-0.092	-0.125	-.163*	-0.004	-0.049
To reflect your previous life?	0.035	-0.094	-.135*	0.074	0.013	-.163*	-.140*	-.168*	0.080	-0.104
To dissolve open aspects of your life?	0.011	-.135*	-0.011	-0.034	-0.101	-0.093	-0.066	-.183**	0.008	-0.007
To plunge into beauty of nature?	-0.108	-.129*	-0.057	-0.030	-0.065	-0.021	-0.012	-.224**	0.011	-0.121
To dwell at a place of quietness and peace?	0.035	-0.043	0.021	0.103	-0.085	0.041	0.034	-0.040	.133*	-0.051
To find inner peace?	-0.001	-0.096	-0.061	0.081	-0.016	-0.036	0.058	-.151*	0.062	-0.052
To find meaning in illness and/or suffering?	-0.022	-0.041	0.063	-0.027	-0.022	0.097	0.031	-0.084	0.028	-0.091
To talk with someone about the question of meaning in life?	0.014	-.166*	-0.079	-0.043	-0.113	-0.059	-0.049	-.190**	0.019	-0.090
To talk with someone about the possibility of life after death?	-0.021	-0.047	-0.124	-0.012	-0.084	-0.005	-0.020	-.162*	0.036	-0.048
To turn to someone in a loving attitude?	0.043	-0.070	-0.066	0.046	-0.032	0.030	0.052	-0.090	0.083	-0.045
To give away something from yourself?	0.009	-0.043	0.003	0.049	-0.005	0.011	0.057	-.125*	.129*	0.056
To solace someone?	0.016	-0.068	-0.040	-0.001	-0.014	-0.016	0.039	-0.095	-0.010	-0.108
To forgive someone from a distinct period of your life?	-0.044	-.160**	-0.019	-0.033	-0.055	-0.016	0.033	-.118*	-0.023	-0.038
To be forgiven?	0.063	-.191**	0.013	-0.053	-0.045	0.018	0.047	-.165**	-0.008	-0.104
To pray with someone?	0.031	-.159**	0.005	-.136*	-.149*	-0.006	-0.015	-.148*	0.005	-0.076
That someone prays for you?	0.000	-.129*	0.034	0.002	-0.049	0.020	0.058	-.137*	-0.035	-0.116
To participate at a religious ceremony (i.e. service)?	-0.048	-0.021	-0.039	-0.085	-0.080	0.038	0.038	-.218**	-0.041	-0.061
to read religious/spiritual books	-0.007	-0.056	-0.034	0.032	-0.029	-0.019	0.098	-0.112	-0.020	-0.066
To turn to a higher presence (i.e. God, Allah, Angels, Oneness)?	-0.068	-0.104	0.004	-0.013	-0.058	0.058	0.025	-0.069	-0.069	-0.003
For being complete and safe?	0.000	-.205**	0.013	0.014	-0.062	0.023	-0.013	-0.108	-0.023	-0.077
To feel connected with family?	0.023	-0.074	-0.001	0.003	-0.083	-0.021	-0.097	-0.002	-0.025	0.015
To pass own life experiences to others?	-0.066	-0.005	-0.007	0.070	-0.018	-0.029	0.045	-.141*	0.030	0.019
To be assured that your life was meaningful and of value?	-0.053	-0.061	0.024	-0.005	-0.050	0.056	0.107	-0.085	0.044	-0.049
To be re-involved by your family in their life concerns?	-0.071	-.146*	-0.055	-0.009	-0.104	-0.054	0.022	-.176**	0.035	-0.026
To receive more support from your family?	-0.057	-.146*	0.015	0.029	-.141*	-0.017	0.024	-.146*	0.019	0.005

4.10 Relationship between spiritual needs and occupational balance

This section provides the result findings of the relationships between spiritual needs and health related quality of life and occupational balance.

There were significant negative relationships found between religious, inner peace, existential as well as actively giving. (r = -.165**) sufficient variety of different activities, (r = -.224**) sufficient variety of different activities (r = -.190**), sufficient variety of different activities (r = -.141*) as well as finding activities over demanding (r = -.205**). There were positive significant relationships found between finding activities over-demanding and religious (r = .191**), inner peace (r = .129*), existential (r = .166*), additional (r = .205**).

There were significant relationships between having sufficient variety of activities and religious (r = -.163*), inner peace (r = -.224**), existential (r = -.183**), actively giving (r = -.141*) and additional (r = -146*).

4.11 PHASE TWO: QUALITATIVE RESULTS

In the second phase of the qualitative results, three themes were identified together with their categories and sub-categories that emerged from the thematic analysis (Table 31).

Table 31: Themes, categories and subcategories

4.11.1 Themes	4.11.2 Category	4.11.3 Subcategory
"Trying to live healthy by accepting my chronic illness"	Living with chronic illness	Acceptance of chronic illness Coping with body pain Deal with challenges and frustration
	Healthy decision-making	Healthy decisions Taking my tablets I'm not going to let it Understanding your limitations
	Self-management	Coping with stress Everyday stressors Basic needs Ways of coping
The things we used to do are now challenging	Engaging in Occupations	Engaging in occupations Sleep and rest I'm going to start all over again now start coaching everything
	Occupational demands	Negative experiences Work stress and job demands We have lots of things to do still
Spiritual experience through the journey of life	Elements of spirituality	Importance of spirituality My belief in GOD Part of who we are Patience with self Religion Connecting with others Therapeutic relationships Reflections of transformation Give me meaning and purpose Good things that you can go back on
	Attributes of spirituality	Sharing and learning through experiences from family and friends Living humbly with neighbours Being aware of your surroundings Give back to the community Positive growth in environment and attitude Expressing your feelings to love ones
	"You can't stay cross with anybody"	Forgiveness /making things right Hope Gratitude Letting things go Tranquillity To see the smiles on the faces Respecting one another Value family Thoughts and emotions

4.12 Theme one: "Trying to live healthy by accepting my chronic illness"

Themes	Category	Subcategory
"Trying to live healthy by accepting my chronic illness"	Living with chronic illness	Acceptance of chronic illness Coping with body pain Deal with challenges and frustration
	Healthy decision-making	Exercises Taking medication and rest Inner strength Understanding your limitations
	Self –management	Coping with stress Everyday stressors Basic needs Ways of coping

The first theme contextualises how the participants tried to live healthy with their chronic illnesses. The title of the theme emerged from one of the participants who said, "*I'm trying to accept and it's not something easy*" (Nita). Furthermore, this theme highlights how the participants faced the challenges of living with chronic illness. However, it has been noted that the participants managed to find other ways to accept and cope with their chronic illnesses and improved their quality of life, health and well-being. Therefore, theme one consists of three categories: 1) Living with chronic illnesses, 2) Healthy decision-making and 3) Self-management.

4.12.1 Living with chronic illness

This category highlights the importance of living healthy with chronic illnesses irrespective of the challenges and sufferings. In relation to living with your chronic illnesses, the participants highlighted that they had learned 1) acceptance of chronic illness, 2) coping with body pain, 3) dealing with challenges and frustration.

In describing the acceptance of chronic illness, the participants highlighted that they found ways to deal with their illnesses in order to carry on with life. This is evident in what Nita and Felicity had to say when they share their views about acceptance of chronic illness. These participants denoted that telling oneself that you are sick seemed to influence how they perceive their health and well-being. Therefore, the participants highlighted that acceptance seem to play a vital role in the participation in activities. As reported by Nita and Felicity in the following extracts.

> *"I'm trying to accept the arthritis. It's not something easy, in the morning I can't use my hands, and stuff just fell out of your hands"*. (Nita)

> *"With my illness, I've got high blood, cholesterol and heart and osteoarthritis. I had to accept what I have. If you accept, what your illness is. You just go on with your life as it is doing your stuff that you do. If you going to say, okay, I am sick now, now you are going to leave that stuff that you were busy doing. You're not going to become better"*. (Felicity)

Coping emerged as an important element of living with chronic illness among the participants in the current study. Three of the participants (Haley, Nita and Nur) shared that their body pain often last for days that appeared as a barrier to engagement in diverse activities. These participants reported that they had to cope with their body pain using different methods such as understanding of their body.

> *"Die daily ding dis nie elke dag dieselfde nie. Dis soos van Maandag tot na vandag toe, Woensdag, is drie dae. Vir die drie dae het ek net gelê want ek het baie pyn"*. (Haley)

["The thing is that every day is not the same. It like from Monday up until today, Wednesday, that's three days. I was just laying because I had a lot of pain". (Haley)]

"I said I don't sweep, I can't sweep and I can't mop. I make up my bed, but if I can't then I leave it because my lungs are very bad". (Nita)

"You see, when you have pain we don't want to do anything. Ag, I am sick, I want to sit still. You see. I do not want to do that. When you think, you are sick; you are going to be sick. I do not want to be like that. That is my motto. I do what I want to do". (Nur).

In supporting Haley, Nita and Nur, one of the participants shared that it was important to get some time to rest in between activities, which assisted in coping with the body pain. This is evident in what Gloria said.

"*Soos nou, vernaamd soos nou stryk, dan raak die skouer weer so bietjie moeg. Ek moet so rus-rus met die stryk. Of vensters was, sulke goete nou because dan kan ek nie manage met die skouers nie"* (Gloria).

["Like now, especially ironing, the shoulder gets a little bit tired. I must rest in between while ironing, or window washing stuff like that because otherwise I cannot manage with my shoulders". (Gloria)]

Body pain is one of the difficulties that seemed to influence people living with chronic illness on their daily life. Participants spoke of how pacing activities assisted them in coping with the body pain. Pacing activities also appeared as an enabler that the participants could use, as evident in what Nita shared.

"My *belief is that you must start first dealing with the problem. I take it day-by-day, step by step. You cannot just rush into things. It is going to take time. As we are*

being taught also how to control the pain and stuff, I take it step by step, time by time". (Nita)

Participants reported that body pain is something that they had to live with as part of chronic illnesses. Hence, Nur mentioned that he tends to use medication if it was necessary, as highlighted in the following extract.

"The pain is there, I take tablets when I really need the tablets. That is my story". (Nur)

However, some of the participants highlighted that using medication on daily basis could be a problem, as it might lead them to be resistant to their tablets. The participants seemed very aware of the implication of taking pain medication on daily basis, as reflected in the following quote from Haley:

"Pille wat ek moes gevat het werk nie met my system nie. "maar die pyn sal nooit verlig nie want die pyn bly dieselfde want daars 'n tyd wan die tablets nie werk nie en dans daar 'n tyd wan dit weer werk". (Haley)

["The tablets that I must take do not work with my system, the pain will never be relieved because the pain is always the same, because there is a time that the tablets do not work and then there's a time when the tablets works again".] (Haley)

Dealing with the challenges seemed to be a barrier to engagement in activities among people living with chronic illnesses. This was captured by Sifiso's comments, where he was specific about the activities such as opening and closing taps. It was evident from Sifiso's comments that body pain resulted in dysfunction. However, Sifiso reported that he had to ask people to assist him to perform some of the important activities.

"So painful here [pointing his arm]. *Even sitting down, there are so many pains when I move or if I kneel. Even me, when I open that tap here and at hospital, it's not easy to open. I need somebody to open. It's not easy when I use this one got so many pain I can't open.*" (Sifiso)

Feelings of inability to engage in activities tend to create a deep sense of hopelessness and frustration among the participants. This is indicated in a quote from Gloria:

"It can make you to feel very frustrated because it must be done and nobody is there to help you to do it. So you sit there, you do not have the energy to do it, you do not feel well. Then you feel frustrated because just looking at it, it must be done but you cannot manage to do it. It makes you to feel frustrated". (Gloria).

*"I was pissed with myself laying there in hospital for a year and a half. After the operation, I had to do another operation wasn't right. I had to have more operations". (*Nur)

There were times that participants seemed to struggle with rest and sleep because of the symptoms related to their chronic illnesses. Participants have reported experiencing pain, headaches, and high blood pressure.

"Nou, ek weet nou nie of dit nou laasweek is of wat nie, because ek het nou laas maand en die maand wat hulle gesê het my bloeddruk is baie laag. Nou het ek nou 'n probleem wat ek opstaan in die oggende, dan staan ek op met daai kopseer. Nou moet ek nou gaan vroeg eet om pille te kan vat en die pyn te kan laat bedaar. Ek weet nie. En saam met die hot flushes wat deur die slaap, vir my baie uit my slaap uithou". (Gloria).

["Well I don't know if it was last week, because last month they told me my blood pressure was very low. Now I have a problem when I get up in the morning, I wake up with a headache. Then I have to eat very early to take tablets so that the pain can ease. I don't know and on top of it the hot flushes that keep me awake at night". (Gloria)]

4.12.2 **Healthy decision-making**

This category describes how the participants made healthy decisions as part of mind shift in order to try living with chronic illnesses and enhance their health and well-being. Furthermore, healthy decisions are related to exercises, taking medication and rest, inner strength as well as understanding of limitations.

In contemplating about the actions for healthy decisions, the participants decided to engage in physical activities such as exercises. This is evident from both Felicity and Nita's comments as they identified ideas that would help them to be physically active. In addition, the participants reported that they have a role to play in their lives to ensure that they are healthy.

> *"I'm going to start something. I spoke to my husband. I told my husband what I have got in mind. I said to him that the doctor said I must start exercising. I said to him, okay, I am finished working now. I am going to try and get some apparatus for me to do these things…. I do my exercises from 9 o'clock till 10 o'clock"*. (Felicity)

The participants made internal reference by reflecting about their lifestyle of living with chronic illnesses and unhealthy choices. These participants realised that there was a need for change in their lifestyle as they were dealing with illnesses and it was their responsibility to ensure that they took action as reported by Nita:

"I always say, we all sitting here today, never knew we will have these illnesses. I try to live healthy as possible, I try to do healthy stuff as possible. Okay, I was not out of order or anything in my younger days, but today I try just to do the healthy things where I can. As I said, it's my life. If I don't look after my body, no-one is going to". (Nita)

Taking medication and rest emerged from the participants' discourse as part of healthy decisions as a form of promoting coping strategies. Three of the participants, Felicity, Nita and Bibi, all shared that they were able to cope with everyday life of having chronic illness which was part of quality of life and relaxation. This is evident in the following extracts:

"I take my tablets and I rest". (Felicity)

"I take my tablets and I go and lay down, or she will tell me no, just go ... or I'll go and sit in the front room just to have that relaxation until I feel well now I can move again". (Nita)

"Yes. Taking the medication help me cope with my everyday life, with the medication I was coping a lot better than before". (Bibi)

Living with a chronic illness seemed to negatively influence human beings' emotional and physical well-being. However, participants' self-determination appeared as an enabler of inner strength that motivated the healthy decisions among the participants like Nita, as indicated in the extract below.

"It puts you down in life. Really, it puts you down because it is like you are used to doing all those things. I don't know, my point of view where myself is concerned, I'm sorry, but I'm not going to let whatever is going on with my body to put me down, because like I said before, it's only myself that can build myself up. And I'm not going to let nothing put me down in life". (Nita)

Participants' understanding of the limitations related to engagement and participation was identified as part of restrictions that the participants managed to deal with in their lives. Here, acknowledgement is made by the participant feeling confident that she is able to do things for herself and set out her activities for her to manage daily so that she can have improved quality of life and health and well- being.

> *"Dan moet ek eers 'n bietjie sit so dat ek by kan kom en as ek reg is dan moet ek maar weer aangaan waarmee ek besig was, of waar ek gelos het"*. (Haley).
>
> ["I must first sit a bit so that I can feel a bit better and then I must go on with what I was busy with doing or where I left what I was doing".] (Haley)
>
> *"I can do now things for myself. I don't stay there where the pain is. I still do my daily tasks that I must do, but the first thing I do is, okay, when I finish my prayer"*. (Felicity).

This theme creates an ambiance where participants reflect on their self and how they need to manage themselves in relation to their health condition and their current environment that they are living in.

4.12.3 Self –management

This category focusses on participants' ability to handle their stressors and how they cope on a daily basis with daily living and maintaining quality of life and health and well-being.

How the participants deal with their stress is of vital importance as part of maintaining their health and well-being. This is evident in the different methods used as expressed by Felcity, Bibi, Nur and Sifiso.

"I just pray and we see that we're less outside to prevent like this provoking and all this remarks and that. I started to draw me more in my house or in my yard, just not to see to the things that stress me out". (Felicity)

"Ek worry nie oor stress nie. Ek het nie tyd vir stress nie. Enige een wat my 'n probleem gee, stap ek weg. Eers het ek getrip, maar nowadays, ek kyk alles verby. Gaan na my kamer toe, maak die deur toe. Worry nie wat buitekant aan gaan nie". (Nur)

["I don't worry about stress. I don't have time for stress. Anyone who gives me trouble I walk away. I used to get angry, but now a days, I look pass things. I go to my room and close the door. I don't worry about what is happening outside".] (Nur)

"I have stress, but I just take it as it comes. I don't have a way of dealing with it. I just deal with it". (Bibi)

"As you're talking of the past and about your friends, your friends sometimes gives you the power to forget about what is happening. So you get it out the stress. You don't think about what's happened before and what I did" (Sifiso)

Participants shared that they need to find ways to deal with their past issues so that they would be able to live happily and cope with stressors. The participants mentioned that they have to move on with life because God provides them with the strengths for becoming. A deep sense of becoming has appeared as an important aspect of the participants, as they had an opportunity to share their feelings about letting go of their past and face the future.

"I think it's important to deal with the past, or should I say deal with the situation before it becomes past. Because if it's still something that's nagging on you, it's

going to keep nagging on you no matter whether you go to the future or present. It's going to affect you negatively. So it is important to deal with it". (Bibi)

"Ja, is die waarheid wat die lady Sê wan die past. Jy kan nie die past laat hang nie. Die Here wil nie hê ons moet dit doen nie, om aan die past the hang nie. As die past verbygaan, gaan aan. Is elke dag vorentoe. Kyk, hier begin ons alweer die nuwe jaar ook. Ons kan nie aan 2016 se ou goed hang nie en 2017 is alweer daar nie. Soos jy aanhou gaan, hoe ouer jy raak, raak jy meer kragtig. Die Here gee jou krag om aan te gaan". (Haley)

["It is the truth what the lady is saying about the past. You can't hold on to the past. God does not want us to, to hold on to the past. Go on the past is gone, look ahead every day. We are starting the New Year again as well, we can't hold on to the things of 2016 and 2017 is here. The older you become, the stronger you become. God gives you the strength to carry on".] (Haley)

The affliction of losing a relative or someone close contributes to increased levels of pain and stressful environment, thus affecting the chronic sufferer's health and well-being as reflected by Haley

"Ek het nie stress gehad tot nou nie maar op nou op die oomblik van laas week was my pa op sterfte. Nou het ek ' baie stress, want hy's nou daar, hy lê nou daar, hulle kan nou niks maak nie. Ambulans gebel, ambulans sê hulle kan niks maak vir hom nie. Sy rug het al gate in. As ek so gaan na hom toe om hom te bad en dan is dit vir my so painful, dan moet ek pille drink, ek moet dit doen en daai doen. Ek vra vir my skoondogter om vir my te help met hom en so aan, en 'n ander lady wat my help met hom. Maar dit bou nou baie stress nou op my. Dis vreeslik baie stress om hom soe te sien". (Haley)

["I did not have any stress until last week, my father was on his death bed. Now I have a lot of stress because he lays there and they can't do anything for him. Called the ambulance, they said they can't do anything for him. His back has wholes in already. When I go to him, to bath him it's very painful. Then, I must take tablets because I must do this and that. I have asked my daughter in-law to help me with him and another lady that assists me. This is building a lot of stress on me as it's terrible to see him like this".] (Haley)

Some of the participants described how a simple physical activity can be challenging as they found it difficult to engage in basic activities of daily living such as bathing. The participants shared that adverse effects of the chronic illnesses tend to create more stress and pain.

"Sometimes it helps, sometimes not, depending on the weather. There are days that I can't get out of my bed. There is somebody that can assist me at home, helps me". (Nita)

"Daar's nou nie ander manier nie, want jy moet maar nou net sit want daar's anyway 'n stryd. Jy's meer oor jou pyn. Jy kan dit nie vat nie. Jy kan nie eens in die water nie."(Haley)

["There is no other way, you just need to sit down because it's a battle. One is more over the pain and can't handle it. You can't even get in the water".] (Haley)

Caring for one's self through patience, is one other way that this participant expressed as a way of managing her health and wellbeing.

"As you say, every day you take it one step at a time, one day at a time, because that's what God ... we mustn't worry about what to happen, what you're going to eat and what's going to happen tomorrow. Worry about the day as today". (Gloria)

Another element of everyday stress discussed by participants is how the struggle of not being able to access basic needs can increase your pain levels and decrease one's quality of life, health and well-being. Discussed by Gloria and Nikita

"Like me, sister, many years ago I did suffer a lot with migraine, and I was not here in Delft. I was staying in Lavis, and I was attending the Lavis day hospital. I was under the day hospital. One of the sisters there had to sit with me about an hour because I was struggling a lot alone. I'm the only breadwinner for my children. I don't get support for my children. When the time like this is coming for Christmas then I'm starting to stress because the children must I have clothes and food. She advised me one thing, to face the problem" (Gloria)

"I know everybody of us also, including myself, some of us don't maybe have the finance to go buy stuff. It's sometimes very hard and difficult for us to cope. Some can do. Some can go and get to buy that or this, but some of us can't, you know, have that maybe. But the only thing I can say of my part is, where I see I can, I go for it, if I can't then, you must just try and maybe see where you can do it on a different way maybe to help you".(Nikita)

Bibi and Nikita placed emphasis on positive coping methods and staying focussed which contributed to a healthy lifestyle and to their health and well-being and acknowledges that they will not let their chronic illness define their lives.

"I just switch it off. I try not to think ". "Just sorting it out when it comes" (Bibi)

*"But I'm sorry, I'm not going to let this put me down in life… If I can still do a difference in life, I'll still do it because I always say, our children are so precious for us today. I mean, if I look at myself, I've got two of my own". (*Nikita)

4.13 Theme Two: The things we used to do are now challenging

Theme	Category	Sub-categories
The things we used to do are now challenging	Engaging in Occupations	Engaging in occupations Sleep and rest I'm going to start all over again now start coaching everything
	Occupational demands	Negative experiences Work stress and job demands We have lots of things to do still

This theme deals with the participants' perceptions about the daily occupations of the individuals living with chronic illness. In addition, in this theme the participants highlighted the challenges they experience living with a chronic illness on a daily basis while endeavouring to engage and accomplish tasks expected of them to do as well as the tasks they used to do for fun. The theme comprises two categories 1) Engaging in occupations and 2) Occupational demands.

4.13.1 Engaging in Occupations

Engaging in occupations such as physical activity like exercises provided opportunities for some of the participants to strengthen their hearts and to improve lung and skeletal function. These experiences contributed to the participants' motivation to engage in important activities that they used to perform before but in a different way. Participants highlighted that incorporating exercise into their daily living is an important factor that enables them to promote their health and wellbeing as shared by Haley, Nita and Sifiso.

> "Ek *is dieselfde geval, want in die oggend loop ek vir oefening ek loop met my voete. Ek loop elke oggend half ses dan loop ek my meisie kind weg werk toe dan gaan ek terug en dan loop ek weer die distance. Ek loop so omtrent so twee ure aanmekaar en wanneer ek terugkom vat ek my breakfast, my tablets. Dan maak ek my bed op en maak skoon wat ek kan doen".*(Haley)
>
> ["I'm in the same predicament, in the morning I walk with my feet for exercise. I walk every morning at half past six, I take my daughter away to work and then I walk back and that's quite a distance. I walk approximately for two hours in one and then when I get back I have my breakfast, my tablets. Then I make my bed and clean what I can manage".] (Haley)
>
> *"I try also there to work with my lungs. I try and do the, or I ask somebody that been taught at home how to do the exercises on the lungs, and that is actually a very good thing, that you don't make yourself used to the pumps and stuff. Just try and exercise the lungs".* (Nita)
>
> *"I then take my stick and exercise; I take anything like a bottle to exercise my hand and a ball a little soft ball. On Monday the sisters came to my house to give me exercises and to work on my hand".* (Sifiso)

The participants expressed the positive influence of exercises and prayers in their lives. This was important as the participants felt that exercise was vital to enable engagement in a variety of activities daily. Praying is one of the key meaningful activities that the participants perceived as an enabler for their families to have gratitude and gratefulness.

> *"Besides, okay, we do our prayers. My husband does his prayer before he leaves. Before the kids go to school, there is always a prayer in the morning and in the evening. That is the rule of the house. My husband stands there and he does his prayer. When I wake up in the morning, sometimes I wake up at five, sometimes at four, it depends. First thing I do, I say, Thank you Lord for another day. That's the first thing I always do"*. (Nita)

Participants shared that they grappled with engaging in meaningful activities because of their body functions and structures that seemed to be restricted by their hands and lungs as expressed by Sifiso, Nita and Felicity.

> *"More special for splash because this hand is not working"*. (Sifiso)

> *"But as I said I don't sweep, I can't sweep and I can't mop. I make up my bed, but if I can't then I leave it because my lungs are very bad"*. (Nita)

> *"Sometimes it's a challenge to do things and sometimes it's not a challenge because your body is letting you do it. Sometimes the body do not want you to do it. Not every day is the same. Anybody can tell it. Sometimes you want to do the exercises and sometimes your body do not want to do it. But you're forcing yourself to do that stuff"*. (Felicity)

Rest is perceived as an important element of persons living with chronic illness, therefore, balancing activities with sleep and rest seemed to enhance participants' functional well-being. Participants reported the benefits of resting in between activities, as they believed that it helps

them to recuperate and listen to their bodily needs knowing that they can continue with it again. This is supported by the extracts from Gloria and other participants.

"As ek nie meer kan nie dan stop ek maar nou net daar en verder gaan ek maar, sit maar daar of gaan na iemand toe en gesels en dan kom ek weer terug". (Gloria)

["If I can't anymore, I stop just there and go on further or just sit there or I go to someone to conversate and then I will come back".] (Gloria)

"And when I do feel like that I take my tablets and I go and lay down, or she will tell me no, just go, leave it or I'll go and sit in the front room just to have that relaxation until I feel well now I can move again... Even if I'm in a store, doesn't matter, I go see where I can just sit and have that break. That is what I do. I don't go overboard I don't force myself. I feel my lungs can't then I go and I sit. If I feel my hands don't want to lift and my foot doesn't want to move I sit little, I rub it, I do exercise. I don't care if I'm in a store and many people looking at me, I don't bother. It's my health and I must look after it. Nobody is going to do it if I don't. (Nita)

"If I don't want to do nothing, I just don't do it. If I have to go out, I have to go out. This is the problem. If I don't do it I don't know what's going to happen". (Nur)

"Maar die ander werke doen ek in die huis normaal weg, werk en bietjie rus, werk bietjie rus, vernaamd as ek kooi opmaak in die oggende, en met die vee en sulke goete. Dit lyk vir my sulke take werk nogal op my baie, veral in my lower back. Maar ek vat dit maar so step by step. Ek oorwerk nie vir my, vernaamd as ek voel ek kan nie manage, ek het nou 'n pyn, dan vat ek net 'n pil en rus en kyk maar weer môre hoe voel ek om dit verder te doen". (Haley)

["The other work I do in the house like normally, I work and rest a little, work a little and rest, especially when I make up the bed in the morning and sweeping etc. it looks like such tasks works a lot on me, especially on my lower back. I take it step by step. I don't over work myself, especially if I can feel that I can't manage, I have pain. Then I take a tablet and rest and then see how I feel tomorrow to carry on further".] (Haley)

Sleep is one of the occupations that the participants were concerned about as they live with chronic diseases. The participants were able to identify the stressors that they were experiencing in their lives that seemed to negatively influence their resting and sleeping patterns. The participants reported that they tried to use the tablets to assist them with sleep. However, the participants shared some of the stressors of their daily lives that affected their sleep including thinking about tomorrow, kids, house and families. This is evident in the extracts from Gloria and Bibi who shared how poor sleep seemed tend to affect their functioning.

"That sleeping tablet, if you do take that sleeping tablet, if you've got something in your mind that's stressing you, that sleeping tablet doesn't even help. You can't sleep, although you use it, you can't sleep. Because I do get it here by the hospital to drink every one, that yellow one in the night to drink in the night, but 11 o'clock, 12 o'clock maybe in the night I'm still awake. Sometimes I do try I don't even drink one maybe in the night to try to see if I'm going to get asleep. It's just one and the same. Because that's why I say you mustn't have something too much on your mind that you're thinking about. That's when you stay up because you're thinking about your troubles, that's why you can't get asleep". (Gloria)

"My mind is forever running around, thinking about tomorrow, thinking about the kids, thinking about the house, thinking about my mom. Just about everything. The normal stresses of every day. Like I told you, stress one day at a time. I don't sleep. I really don't sleep. I don't know why. I get sleep tablets. The tablets are not working. It's not working. He give you eight, nine tablets you must take, but really I don't know what is the problem. It's not like ... when I sleep, I sleep. If I can't sleep, I can't sleep". (Bibi)

There was a need for developing personal skills that the participants felt could assists them to start all over again. One participant shared some internal drive that they need in order to revive the inner self and creates a deep sense of the spiritual need to fulfil desired goals.

"I'm going to start all over again now start coaching everything". (Nur)

4.13.2 Occupational Demands

In relation to occupational demands, the participants reflected on the demands they had to face as they engage in a variety of activities. This included stressful nature of the activities, however, it did not affect the participants' engagement. For example, Nita and Sifiso reflected on the inner need and willingness to work. The participants shared that they had to deal with feelings of hopeless and inability to achieve life goals pertaining to their work.

"As ek nog kan werk dan sal ek dit doen [if I still can work then I will do it]. *Honestly, I'll still work. Okay, my work is more of a stressful nature".* (Nita)

"Even me, I'm working on the garden, but now I cannot manage to work in the gardens, because I got no hand to help me". (Sifiso)

Among some of the occupational demands that were mentioned by the participants, it seemed to be related to the weather and fatigue that had a negative influence on functional and physical well-being. Rest was one of the strategies that the participants found to be effective for them in order to cope with the occupational demands. The participants seemed to be aware that the weather tend to influence their functioning particularly winter, which appeared as a barrier to those with arthritis and pain as discussed by Gloria

> *"When I start to feel tired ... the tiredness by me start always by the lower back. Then I go and rest a little. If I still feel that the rest did do something to carry on, then I carry on. Maybe if I can't manage then I leave it for the next day…So I like to work, to keep busy, because when I sit too long then I get too tired of sitting, then I get up and start to look what can I do. I have something to do every day. That is why I can look there by my place when I get up in the morning, especially now in the summer is the time that I like to work. Because you know, winter, you know with the arthritis you've got pain".* (Gloria)

The participants made reference that occupational demands appeared as something they lived with in their lives. One participant shared that as an adult was aware of the importance of prayer, however, the participant had negative feelings towards Mosque because of parents pushed them to go for prayer. This indicated the unwillingness to engage in activities that seemed to influence the participants' emotional well-being. In addition, the participants did not want to perform it because of what occurred as a child on a daily basis, thus finding it difficulty and demanding to fulfil.

> *"Every day we were hit to go to the Mosque. Afterwards, why must I go? If I'm not ready to go, why I had to go. It's almost like I'm taking my religion for a joke because I just have to go, go. But my heart is not there yet".* (Nur)

Feelings of inadequateness and hopelessness was displayed by some participants who indicated that they were unable to engage in paid work, which appeared to have negative influence on their physical and functional wellbeing. Despite the struggles related to occupational demands that participants faced in their chosen living environment, Nur displayed feelings of positivity and denotes that the inner self has the need to do and achieving their outcomes set by the self.

> *"I agree with him. When I must go back to work in a factory, the things that I did there, it's that iron bath that we must pick up, walk in and throw it over and then work with it, it's twenty garments ... now it's twenty trousers, legs, then it's forty leg parts that's on you. Now you must take one ... your speed, they're not gonna sukkel* [going to struggle] *with me"*. (Felicity)

> *"It's not the same. When you have knee problems, you can't do the work you want, that you've done before the time, and the boss is not going to keep you on because you have to do the same thing you had done all the years. See, I had that problem. They boarded me from work… "We have lots of things to do still"*. (Nur)

4.14 Theme Three: Spiritual experiences through the journey of life

Theme	Category	Sub-categories
Spiritual experiences through the journey of life	Elements of spirituality	Importance of spirituality Religion Part of who we are Patience with self Supporting and connecting with others Therapeutic relationships Reflections of transformation of some sort Things that give me meaning and purpose There's always good things that you can go back on to
	Attributes of spirituality	Sharing and learning through experiences from family and friends Living humbly with neighbours Being aware of your surroundings Give back to the community Positive growth in environment and attitude Expressing your feelings to love ones
	"You can't stay cross with anybody"	Forgiveness /making things right Hope Gratitude Letting things go Tranquillity To see the smiles on the faces Respecting one another Value family Thoughts and emotions

In this theme, the participants' perceptions related to the spiritual experiences through the journey of life are described. The third theme further deals with the importance of connecting with others and sharing experiences as to part knowledge as well as doing things that gives one meaning and purpose. In addition, the third theme comprises elements and attributes of spirituality.

4.14.1 Elements of spirituality

Concerning the elements of spirituality, the participants shared their views of how they experience spirituality in caring for their significant ones. The participants reflected on how the caring for elderly had enabled them experience spirituality related to connecting with others.

> *"Many of us are at home today. There is a lot of things that we can do for the elderly. And for me, why I also say ... as I said, I left, I looked after my mom. My mom is now almost six months she passed on. She passed away at the age of 79 and I looked after her. I always say many of our kids don't want to know, that's your blessings"*. (Nita)

Spirituality seemed to be related to a variety of elements including inner peace, calmness, satisfaction, connection with God and others. This is evident from the participants who expressed that spirituality was important for their health, wellbeing and quality of life. Three of the participants shared their views in the following extracts.

> *"I would say my God give me the inner peace if I'm praying to Him, I feel calmness. Then if I really mean what I tell Him then he is more than able to satisfy my soul and give me the calmness"*. (Felicity)

> *"Inner peace, it's something I put into others and reap from it. That is good. That's the inner peace that I get, to see that it doesn't matter who or what you are, what race you are, it doesn't matter, to see that person go forth in life"*. (Nita)

> *"I think it come from God to give you strength"*. (Sifiso)

In relation to religious and spiritual beliefs, the participants shared that they engage in spiritual practices such as prayer and reading the bible, both of which contributed to improved

health, wellbeing, and quality of life. The participants (Felicity, Nur and Haley) shared how they incorporated their religious and spiritual beliefs in their daily life, which depicted their strong feelings of believing and having faith in God.

"You must never doubt yourself. You must believe you can and with the help of the Almighty, you can do it. Not you cannot. You must not doubt that you cannot do it. You must think forward. You must think forward with a positive mind…. Then all of a sudden then, I get a blessing from that one come... I heard you got a soup kitchen and that other lady said I must give you some carrots. Then the carrots are there. Then all the stuff ... then the other lady say, come fetch the bread man, and that is how ... I do not ask for it. It is just a blessing. Someone sent it". (Felicity)

"But the main thing is your Creator, God must be first, He must be the centre of your life. Whether you do not want to go to mosque, whether you do not want to go to church, you must believe and you must follow, because He is the one that gives you the grace and the mercy. He gives you the strength to get out of that bed every day". (Nur)

"Ek tel die Bybel op en ek sit elke dag met my pa. Ek lees vir hom 'n vers uit, al lê hy nou net daar. Dit sal ingaan. Ek moet met hom praat deur die Bybel. Ek moet vir hom sê, pa, ek praat vandag deur die Bybel met jou dat die Here jou kan genees. En as dit tyd is dat die Here jou neem dan moet die Here jou maar neem". (Haley)

["I pick up the bible every day and sit with my father. I read a verse from the bible for him, even if he just lays there. He will take it in. I must speak to him through the bible. I must tell him that father am today I will be speaking through the bible to you so that God can heal you. If it's the time that God must fetch you then he must take you".] (Haley)

Bible reading is one of the religious occupations that the participants found to be useful in their lives. It appears that bible reading as described by the participants was part of spiritual need and was an occupation that provided a sense of calmness, strength, comfort from within and the ability to provide spiritual care to others.

> *"As ek die Bybel gelees het, dan kan ek vir u sê ek het nou daai vers gelees ek kry daai uit die vers uit,kom ons wat dit ek kan van dit vat want daar is iets in daai vers wat 'n mens kan leer."* (Haley)

> ["If I read the Bible, I can then tell you what I learned from that verse and I can teach others what I've learned from that verse".] (Haley)

> *"If I read the Bible or a spiritual book, especially the Bible where it speaks of, like the Psalms. if you like now depressed, or if you feel down and you read the Bible and there's a main verse there that you read and you ponder on that verse, that makes it difference in your inner spirit and if you're down it can lift you up. It all depends how you read it, and what you do, what you make of that scripture. You see. You put it in your mind or you can tell that person also what if she was down, maybe we talk and we say, yoh, I went through that and I can tell that person, no, I went to the Bible, I read that verse. And that same verse that I read can help that person"*. (Felicity)

Prayer emerged as one of the spiritual practices that the participants felt had assisted them to cope with challenges in their lives. Furthermore, one participant shared that prayer strengthen their faith in God.

> *"The faith is helping a lot. To pray also is helping a lot sister. It is helping a lot because when I go to bed in the night I pray, when I wake up in the morning I pray.*

When I got that something that's starting to stress me out I pray, then I say that God is going to make a way for that problem to go away". (Gloria)

There were participants who seemed to be concerned about their life after death. This is evident in the following extract which Gloria sharing her view regarding the prayers of doing the right thing for her journey in life. The participant main concern was the spiritual wellbeing of living right on earth before dying. Furthermore, the participants expressed the feelings of uneasiness, as she did not know what to expect after death, yet firmly believes that one should lead a straight life.

" I can't say life after death, what I'm feeling, because maybe ... look I'm dead already, so how am I going to know what is my life going to be after death". (Gloria)

"Daarom moet ons maar nou so bid en bid en die regte pad loop" (Gloria) ["Therefore we must pray and walk on the right path".] (Gloria).

However, one participant shared that they had strong feelings that there is life after death. This is supported by the affirmation with reference to the scriptures that indicate that God promised that everyone would see his coming back.

"There is life after death one day, and we're just going to see that day come, then we will like be surprised what's going to happen that time because He promised us that every eye will see Him one day when He comes." (Felicity)

Part of who we are was shared amongst the participants who described that dealing with every day concerns stems from within individuals.

"I won't say that it takes over. It does have some part in like your every day, but it does not take over. You just somehow deal with it." (Bibi)

Participants shared that supporting and connecting with others appeared as enabler of spiritual care. This important element was identified from the participants' discourse that indicated that spiritual care was not only within the home but in the broader community as well. The participants created a sense of connectedness that related to a supportive environment that enhanced their spiritual wellbeing in order to maintain health and wellbeing.

"Me to sister I'm lucky because I've always got support. My granddaughter she stays with me, she is always there to help me if she sees that I do not feel well. Maybe like the asthma not so well, sometimes I feel so sorry for her it can be 12 o'clock in the night, just hear me coughing, coughing and then she comes to me, every time she comes in the room, come and see that I am all right. So, I have got tremendous support because even if I can't manage to make my bed she is there to do it for me. I cannot complain. I've got always her support because she's always at home."(Gloria)

"I've got good support from my husband. He is supporting me with anything, assists me, and then I have a grandchild there who is 24 he is working. Sometimes he is off. Like this morning he said, ma, you can maar go, I will clean the whole house, so I did nothing. He is busy cleaning the house. They're very supportive". (Felicity)

Regarding the support from the community members, the participants shared that respecting one another as well as connecting with your community members enabled spiritual care and creating togetherness amongst each other.

"My soccer community team was a family. I was their father. Their mothers, they don't have respect for their mothers also, because the mothers don't have respect for them". (Nur)

"There was a lady in our road who was high society, her son was a gangster. They want to go there. They shot him. She didn't know the community is going to stand up for her, helping her to put her son under the ground irrespective it was a little money for flowers and stuff, for the buses and stuff, and we done it. We made a list ... I made a list, send people around, put on the list and stuff, putting her son under the ground. Afterwards she changed seeing the people helping her, respecting her" (Nur)

One participant shared that there were times that community members were engaging in healthy activities such as exercises. This is evident of sharing resources for the benefit of all the individuals who were connected for developing personal skills related to self-management.

"I first had three ladies. One lady, she is still with me, she's 67. One is 56 and the others ... all in their 50's. It is only this lady that is the eldest, she's 67. Okay. I got two bikes, I have this fitness flier, and I got small exercise equipment there. I called them in and we started this exercise group now". (Felicity)

The importance of positive therapeutic relationships emerged from the participants (Haley and Gloria) who shared that their health and wellbeing were enhanced by the relationship they had with their healthcare professionals.

"Jy moet vrede maak met jouself. As een vir my 'n fisio gee, en ek gaan nou uit, my fisio is nou lekker, ek het nou ook lekker my oefeninge gedoen. Ek kan nie gaan kwaad wees dat ek nog pyn het in my arm vir u nie." (Haley)

["You must make peace within yourself. If one gives me physio and I go from there, my physio was good and I done my exercises. I can't be upset for you because I still have pain in my arm".] (Haley)

"The advice I took by the nursing sister. That advice gave me a lot of strength. I had to even to advise a friend of mine to do the same thing, and she said to me, I thank you because that advice you gave me it helped me a lot because". (Gloria)

Participants expressed the importance of reflection on the inner self because it assists individuals to transform their lives and do the correct thing. The participants further indicated that the inner self and within the environment cannot be separated because they are connected to each other. This allows for change in perspective of the inner self as well viewing people and surroundings in a non-judgemental manner, which resulted in participants to making better choices that led to a better health and wellbeing.

"I was a very rude guy. I did not respect anybody, and I changed little by little. I started with me. I started respecting myself and then I respect all the other people. Then everybody changed with me. I was really rude. I was part of a gang also. When I got married, I got out of it. I respect the guys, the guy greet me; ask me for money I will give him. Ask me for drugs money, no ways. I do not give money for drugs, cigarettes. If you need something to eat, I will buy it for you. I do not give you money… Like the guy who was knocked me, I didn't forgive him, and then afterwards I told him, tell the truth. He did not want to tell the truth. And one day the people hijacked him. I did not forgive him yet, because I cannot get to that.

Because they killed him. They hijacked him; they stole all his money of the bank and shot him in the face". (Nur)

These participants Felicity, Nita and Bibi derived the notion of meaning and purpose. One participant expressed that the lack of meaning and purpose in one's life led to unproductivity and monotonous that have negative influence on the health and wellbeing. However, other two participants expressed the need to accomplish things in their life that gives their lives meaning and purpose.

"I achieved a lot in life, but as this guy says, there's still things that I want to achieve in my life, and I still believe and trust it's going to come".(Felicity)

"Well, I don't think my life is very productive, because every day is the same again. Get up, get the kids ready and, every day is the same thing. So, there's nothing productive about it". (Bibi)

"If I can still do a difference in life, I'll still do it because I always say, our children are so precious for us today. A person's life does not stop, it does not matter what your age is. Your life does not stop. There are always good things that you can go back on to". (Nita)

4.14.2 Attributes of spirituality

In relation to the attributes of spirituality, the participants shared that sharing and learning from life experiences appeared as essential elements within family and friends. Two characteristics that resonated with the participants include sharing and learning, which placed more emphasis on the inherent need to share so that family can learn from each other. The

participants reported that they taught their children and grandchildren about the journey of life. It was clear that the participants valued passing legacies to their family as part of sense of belonging.

> *"Yes. That is why I teach my granddaughter. Môre, oormôre sy gaan haar eie kinders hê dan gaan sy haar kinders dieselfde ding kan leer"*. (Gloria)
>
> ["Tomorrow or someday she will have her own children and will be able to teach them the same things".] (Gloria)
>
> *"It can help that person. If someone, maybe you went through a thing and this thing that you took helped you, maybe what your mommy told you, your late mother or your late father teach you what to do when you're in a predicament or what, then someone come with that same problem that you have then you can encourage that person. If that person that person want to take your advice"*. (Felicity)
>
> *"It's for everything. I mean, if you have a problem you have to tell them because they have the same problems. I mean, some of the kids, ag man, we're having a problem we say okay, go ahead and knock your head. Then you come back and we will help you again. You see, sometimes they don't want your help, but then when the problem happen with them then they reflect, my mother and my father told me that way, why we didn't listen to them"*. (Nur)

These participants agreed that sharing about past experiences could have a positive influence on the individual's life. This is evident in the reflections on the changes that occurred through their journey in life. The participants reflected that sharing and learning taught them the importance of attributes such as gratitude and humbleness. Being courageous was perceived

as an enabler that assisted the participants to teach their family and friends to face hardship so that they may reach and attain their goals.

"Yes. I use to talk about it, when we're like in a crowd, like family, then we used to, how was my daddy, how was my mommy, how did we grow up. There was not that, and there was not that, like we have today. Then I think and I look around my place and I see, yoh, look where I'm at today. In my past where I grew up we didn't have that. The TV was not there and there were lots of things that was not there. We had to light candles, we had to make the stove, had to go, and fetch wood, and make the fire and it was smoking. Sometimes we talk about all the past and then we look to like we are now. And we can just say thank you. Who did brought us to it, just Christ that brought us through that we are here today". (Felicity)

"Dit het 'n baie groot effek gehad, want ek het skool gehad tot op standaard 2. Toe het ek op die ouderdom van 11 jaar oud gaan werk. Dit het my geraak van ek het tot op 20 jaar op 'n plaas gewerk. 'n Swaar tyd gehad en om vir 20 jaar die koue en winter deur te druk om met groente te werk is bitterlik hard. Tot na vandag toe dat ek vandag in die Delft kan bly. Was dit nie die Here se wil nie, sou ek nie vandag nog mens kan gewees het nie". (Haley)

["This had a big effect because I went to school up until standard two. At the age of 11 years old, I went to work. This affected me because I worked on the farm for 20 years. I had a difficult time to work in the cold and in winter, I pushed through to work with the vegetables it was bitterly hard. Up until today that I can reside in Delft, was this not the Will of God I wouldn't still have been a person".] (Haley)

"Today's children don't think what you went through. They just want, want. Nice takkies, two thousand rand takkies, five thousand rand takkies that's the stuff that the children want". (Felicity)

Living humbly with neighbours was perceived as part of sense of belonging and connectedness. The participants (Gloria, Felicity and Bibi) deeply expressed and highlighted that the inner being is need of spiritual care so that they may live with others in peace with acceptance and supporting each other. This is evident of sense of community as alluded in the following extracts as it promoted support mechanism.

"Another thing that's very important is to live in peace with the neighbours too, because they are the nearest. If something happens to you and your family is not near that time, family is very important, but you must live in peace with your neighbours also". (Gloria)

"My neighbour is there. If I'm sick and I can't do anything for myself, then I can go to my neighbour because my relationship with my neighbour is fine". (Felicity)

"Well, personally family and friends, like the neighbours, they give that emotional support. Sometimes they give you physical support as well. And without support you're basically lost. You need some kind of support". (Bibi)

"Love your neighbour and your friend". (Haley)

Being aware of your surroundings captured the participants' feelings about the importantance of assets around their communities. The participants felt that the assets around their communities could be used in an effective manner to benefit them.

"I always say, if this community, Delft isn't a bad place. It is some people that make it bad. There are so many potentials in Delft, really. A lot of people, even those that visits the hospital. There are so many people that have qualifications behind them. But because, I don't know, some people are just scared maybe. I don't care. I look forward. I want to go forth if I can do it every day". (Nita)

Some of the participants like Gloria highlighted the importance of being aware of what is happening around their communities and the world. Television was identified as one form of media that the participants used so that they could be aware of the dangers and opportunities within the community.

"Ek hou nie baie van lees nie, maar ek hou baie van om die nuus te kyk by die TV. 'n Mens kan sien wat gaan in die wêreld ook." (Gloria)

["I don't like reading much, however I enjoy watching the news on the television. I can also see what happens in the World".] (Gloria)

Giving back to the community was perceived as one of the attributes of spirituality that emerged from the participants' conversations. The participants' sense of community and belonging appeared as an enabler that facilitated the sharing and giving back in the community. It was clear from the discourse that the sense of community helped the participants to invest the little that they have with community members in need of resources. This appeared as a vital attribute that the participants commonly had to enhance their inner being of spiritual self as reflected by Gloria, Nita and Nur. Thus, it created feelings of gratitude, humbleness, appreciation, and care as well as evoked a deep sense of peacefulness. This aided in contributing to health and quality of life, as well as made a difference in the lives of the community members.

"Woensdae is vir gemeenskap. Twee uur kom die groente . Van oggend het ek uit gekuik toe ont hou ek vandag is Delft Dag Hospitaal toe, gaan sit ek en bietjie gesels en dan van hiervandaan gaan ek om die trok te kry en af laai weer. Dan kom die gemeenskap hier staan en ek deel vir die grootmense pakkies groente uit ". (Haley)

["Wednesday is for the community. Two o'clock the vegetables arrives. I look forward to this morning then I remembered today its Delft Day hospital, will sit and talk a bit, from here I'm going to meet the truck and off load again. Then the community comes to stand here and I will hand the parcels to the elderly".] (Haley)

"But it's nice if you do it. Really. Honestly, it's something nice to do it for somebody else's child. I always say that child didn't ask to be here. We big people decided that the child must be here and I'm listening to what this gentleman is saying". (Nita)

"I was a soccer coach. I was driving a lot of kids. I had a community base, I made food once a month. I can't do it. I mean, it was everything out of my pocket. I don't care about the money and stuff. I give everybody irrespective if they big ones, when it's little ones, I just say stand back, the little ones first". (Nur)

"For me also, I've got this soup kitchen and for me, yoh, winter time, the children like this coming to my house just with the naked, no kimbie, and they're small, they still need ... and that, then they come there, just with a jacket, a big jacket that cover their whole body, then they come. You know, and then I look at them with tears in my eyes. And they're so precious to me just to". (Felicity)

Healthy positive attitude and supportive environment were both identified as assets that could help community members to live with each other in peace. Living in a healthy environment be it within the home or simply just in your neighbourhood, is vital to maintain your quality of life, health, and well-being. Felicity, Nur, Sifiso, Gloria discussed that having a supportive environment is beneficial for one's health and wellbeing, as well as quality of life.

Felicity speaks about the negative influences on how the attitudes of some community members have created a stressful environment on her health and wellbeing and foremost places emphasis that living together in a positive supportive environment will contribute to better outcomes for the community at large.

> *"I've got a problem in my road with this people there in my road. Everything that I do for the community they have a problem with. Everything I give to the people they have a problem now. I don't have a mansion. Now they have now better things like me, now that is what they're bragging and the cars. That's nothing to be because you're not going to go to the grave with that stuff. Now the mother and father is drinking with the kids, with the girl, with all their boys they're drinking, and when they're drunk ... we don't worry, our people in the road don't worry actually with that people because they say they're the richest of the richest".* (Felicity)

Sifiso, Felcity and Nur express, how one's family attitude can either create a supportive environment or create further stress on your health and wellbeing. They report the inherent need for a positive family environment which assists the healing process from inside and outwards.

> *"Talking of the past and about your friends, your friends sometimes give you the power to forget about what is happening. So you get it out the stress. You don't think about what's happened before and what I did".* (Sifiso)

"It helped me a lot. That's why now even, like the children also, don't look at the child make you cross of this, make you cross of that. You must scold your child even if she gets to be rude to you she must go out, because if you just sit and look there because she make you cross, because you're scared now when you're going to scold that child, some of the children today are very cheeky also, they're chatting and everything. Now you bottle in, you don't want to talk. What's the use because you're the one who is suffering. Otherwise, tell the child if she thinks she's too big for her boots she must out of your house". (Gloria)

"Sometimes the support of the family is not always nice. I mean, sometimes they depress you more. When you're sick they press you down. They come with their problems. You have problems, but they bring their problems, you must help them". (Nur)

4.14.3 "You can't stay cross with anybody"

The participants' perceptions feed to their sense of being through finding reconciliation within the storm. It was evident in the category entitled: "*You can't stay cross with anybody*" that was shared by one of the participants. The challenges that the participants faced within their lives quest for improvement of their health, wellbeing and quality of life. Participants drew on important aspects that they had to deal with and work through that supported them in their recovery to enhance their overall quality of life. Forgiveness stemmed from the participants as pivotal in the healing process of improving ones' overall health and wellbeing. One participant shared on three different occasions about the need to forgive the self and to forgive others. This indicated that the participant's level of maturity and awareness about the journey of life because things can change in an instant manner.

"You see, one day my wife and I was cross at each other. She went to sleep, I went to sleep. We did not greet each other and we never spoke to each other. I went to work the next morning, I almost died that morning. A car knocked me. I was lying in hospital for a year and a half. I was in and out in a coma. That is why I said, if I am cross, I am not cross when I get into bed. I make peace. Tomorrow you are going to be cross after that, it is your problem. You can't stay cross with anybody. You don't know if you're going to see that guy to ask him for his forgiveness… When somebody speaks before he dies, but we don't think what that person's giving you, he's asking you forgiveness and stuff, but you don't, you can't take it. I saw my mother pass away on her deathbed… But when I'm going to see him, I will see him, we will stand up together and I have to forgive him. Irrespective of what is going to happen. I have to get him still". (Nur)

Two of the participants echoed each other when they expressed that forgiveness foster sense of peace and becoming. This is evident in the extracts of Bibi and Felicity that indicated that forgiveness tend to release one from the dilemma as well as evokes feelings of peace and serenity from within, therefore, allowing one to move on with life.

"Once you forgive someone you actually make peace with them, which means your life can carry on. Regardless". (Bibi)

"Make peace with yourself, if you forgive others, then you free yourself. Then you can accept actually, what comes your way. Then you can go on". (Felicity)

Hope emerged as one of the spiritual needs among the participants that shared that having hope in one's faith. This resonates with the participants as they developed the desire to

achieve during the difficulties and obstacles faced in their lives. Therefore, the participants felt that hope seemed to strengthen their courage to strive for a better outcome for their health, wellbeing and quality of life.

> *"For one, if I wake up in the morning, then I look out for the day. It's a new challenge for the day, I don't know what's going to happen, but it's a new challenge"*. (Nita)

> *"I was still in pain. I was in hospital still and I mean, I was pissed with myself laying there in hospital for a year and a half. After the operation I had to do another hospital. The operation wasn't right. I had to have more operations and more operations. When I started to walk and stuff, the doctor told you're not going to walk in your lifetime. I told him, you're not God, you're not the guy upstairs. You will see, I'm going to walk, and I was walking"*. (Nur)

Gratitude was described by the participants as a feeling of appreciation of the connections that they had with the Creator. The participants shared that God's love and grace were sufficient to provide sustainability in their lives.

"Your Maker you must follow because He is your Creator and He made you. We could have been gone already, but through His love and His grace that he gives us every day". (Felicity)

Letting go captured the participants' feelings about dealing with past experiences related to difficult situations. Few of the participants (Felicity, Gloria and Bibi) shared that letting go creates a sense of peace and a relief from their shoulders, freeing their mind from negative feelings.

> *"Sometimes it's better not to deal, to keep on thinking about the past every time. Your mind won't rest if you keep on thinking about the past. You must try to ignore*

the past, go on with the future. Otherwise you're just going to feel like you're stuck in the same thing over and over". (Gloria)

"I agree with her. If there's a past rather make it right and sort it out that you've got peace with that one that did something to you, or with the past, maybe with friends or a relative or family, whatever, then you can move on. If you don't make it right you will keep on looking at that thing and that is going to keep on coming back to you. If you can make peace with it and sort it out then you can go on. If not, then you're going to be stuck like the lady's saying. Then you're going to be stuck there". (Felicity)

"I think it's important to deal with the past, or should I say deal with the situation before it becomes past. Because if it's still something that's nagging on you, it's going to keep nagging on you no matter whether you go to the future or present. It's going to affect you negatively. So it is important to deal with it". (Bibi)

Tranquillity is related to one of the elements of spirituality particularly inner peace, as defined by the participants in different meanings for each one. Some participants find tranquillity through relaxing and appreciating the nature. Whereas other participants viewed tranquillity as finding spiritual calmness and inner peace in the lives of the people that they touched.

"I enjoy nature. Just looking at the birds and the trees and sometimes just staring up at the clouds. That's calming". (Bibi)

"*To see the smiles on their faces*". (Nita)

"Inner peace for me is when a child you taught go further from you who gave him the tools and stuff to go further in life, and I mean, I have one player, he was in China through his soccer. Every time he comes back to me, he receives a call from

Bafana Bafana. He's 18, 19 years old now. He had a call up already. I said, no, leave the call up. The call up will come again. Go to China. Go experience in China. And every time he comes pass me, he will ask what he must do. I always have somebody coming back to me. The children I gave tools to go further in soccer and life". (Nur)

Participants reported that respecting the self and others is vital in promoting emotional, social and physical well-being.

"That's the first important thing. Respect. Because if you don't have that, how do you expect that child to respect you also?… You can have nice times but you must know your limit and you must have respect for your kids. And many of us don't do it. We just take it for granted, I'm the mom, or I'm the dad, it doesn't work like that. I always say it must come from both sides. That is why I say, it is nice to do for other people's kids. Many of these kids turn out bad because of their own circumstances". (Nita)

"It's better to have respect especially your neighbours and everybody else, everybody else that's around here to respect. When you respect somebody, then they can respect you and if something happens to you, because you have the respect already, you respect yourself before and respect somebody". (Sifiso)

"My soccer community team was a family. I was their father. Their mothers, they don't have respect for their mothers also, because the mothers don't have respect for them". (Nur)

The value and appreciation of family appeared as an important element of coping with hardships in life. The participants reflected on the spiritual care that is provided by their family, friends, and neighbours which tend to strengthen their emotional, social, physical and spiritual wellbeing.

> *"Family is very important to me. I'm talking about my whole family outside and inside, if one of us go through like a tough time and then our family come together. That's why family for me is important to reach out to them…I will say my family, my neighbours, my friends are very important for me. Mainly my family is because if I've got an open spirit to go say, listen here, this and that and that, then they support me in my shortcomings and that. I don't have to go to my neighbour. I can talk to my neighbour".* (Felicity)

> *"I do have it. I've got 100% now. Even my one daughter that's at school, if she sees me, my mommy don't look well today then she will say, mommy, we're going to make food, I'll make it. Really, I've got 100% support. I mean, I'm sitting here. I don't have to do anything when I go back".* (Nita)

> *"Yes, the family is very important, sister"* (Gloria)

Thoughts and emotions were both mentioned as important aspects that seemed to guide the participants on their views about life. The participants reported that one's brain tends to influence how they deal with their pain. However, occupations such as reading the bible, prayer, painting and singing were perceived as enablers that assisted the participants to cope with their pains that they experience in their lives.

"It's in your brain. If you control your brain, you control your pain. I don't know if you know about it, but I'm doing like that. See I don't take my tablets like 24/7 and stuff". (Nur)

"It helped a lot in many ways. My spiritual, my physical. Because of the fact that I went to painting and singing and that, understand, I was more relaxed, I was more at ease, I could handle things a little bit better because I wasn't so focused on everything is this and that and that. It was more on a steady rate in my brain. So that is what helped me cope". (Bibi)

"It is true. You must never put your mind on that, on something because you haven't got food, you haven't got this, and you need money for this. Now you just sit still and your mind that's whole day in your mind, whole night in your mind, you can't sleep, you're depressed. Do something. Try something or you pray". (Gloria)

"If you're in pain then you don't have to focus just on that pain. You can go in a room, you can pray, you can read the Bible and meditate on the Word and that makes your pain more easier. Then your mind is not on the pain. The mind is on what you've been reading and what you feel what you read makes you better". (Felicity)

CHAPTER FIVE

DISCUSSION

5 Introduction

The aim of the study was to better understand the perspectives of adults living with chronic diseases by examining the relationship between spirituality, health-related quality of life and occupational balance. In this chapter, the significant study findings are discussed and compared with other studies. Therefore, discussion and interpretation of the results are presented in relation to the sociodemographic characteristics of the study participants, participants' spiritual and religious beliefs, relationship between spirituality and occupational balance, as well as relationship between spirituality and health related quality of life. Furthermore, the results are discussed through the lens of the Canadian Model of Occupational Performance and Engagement (CMOP-E).

5.1 Sociodemographic characteristics of study participants

5.1.1 Age

According to the World Health Organization (2008) and Scott, Schaay, Schneider and Sanders (2017), age is one of the social determinants of health among people living with chronic diseases. The highest proportion of chronic diseases was observed among participants between the ages of 51 – 65 years ages. The findings of this study support Lehohla, (2013) who found that older adults aged 55-64 were diagnosed with chronic diseases such as asthma, diabetes, hypertension and arthritis. However, Harvey and Silverman (2007) found that older adults between the ages of 65-74 were more likely to have one or more chronic diseases.

Chronic diseases seemed to affect people of all ages, however, the proportion of chronic illness tend to increase with age, as people over 65 years are more susceptible to the risk factors of non-communicable diseases (Harvey & Silverman, 2007). Furthermore, chronic diseases may negatively lead to limitations in daily activities of living and often reduce the health-related quality of life in seniors (Harvey & Silverman, 2007).

5.1.2 Gender

The findings of this study show that a higher proportion of females (71.6%) that reported that they suffered from a variety of chronic diseases than males (28.4%). This study's findings corroborate other research findings which have shown that women tend to suffer more with chronic diseases and use health care services compared to men (Lehohla, 2013; Waggie, 2007; Bertakis, Azari, Helms, Callahan & Robbins, 2000).

5.1.3 Race

The findings of the study indicated that people of colour and African seemed to have chronic diseases. However, this findings should be explained in caution of the contextual factors related to socio- economic status. Lehohla's (2013) explanation of this may be due to the fact that people of colour and African access public health services.

5.1.4 Marital status

From the findings of the current study, there were more participants who reported that they were married, however, the difference between those who were married and those who were unmarried appeared to be small in percentages. This is in contrast to the study findings of Waggie (2007) who found that there were a large number of community members who were unmarried. The possible reason for the differences could be that families may become of

importance in their lives. Another reason might be that people have started to view marriage as important as well as relocation into the area.

5.1.5 Level of education

The findings of the study indicated that the participant's level of education obtained was either primary or secondary education. However, Janke, Johnston, Propper and Shields (2018) found that being educated had influence in the management of chronic disease. The study of Janke et al. (2018) indicated that having a higher level of education may contribute to better health related outcomes.

5.1.6 Employment status

It has been noted that there was a high unemployment rate within the community with some informal business and low-income occupations (Waggie, 2007). Waggie's (2007) study corroborates with the findings of the current study that most of the participants (50.7%) were unemployed while 7.5% earned an income higher than R3000. In addition, a number of the participants (33.3%) were in receipt of a disability grant or pension. This indicates that the participants struggled to access human needs like subsistence. This finding echoes Scott et al.'s (2017) explanation that living in conditions whereby household, food, and security are a problem, tends to influence people living with chronic diseases. This could mean that people living with chronic disease may not be able to engage in meaningful occupation and take their medication as prescribed. Clearly, the findings of the current study showed that the adults living with chronic diseases tend to share the little that they have with community members.

5.1.7 Participants' spiritual and religious beliefs

The most common faiths that are practised within the community are Christianity, Islam, Hinduism and African traditional belief systems (Waggie, 2007). This could be explained by

the unique findings of the present study that show that the majority of the participants reported to be part of a religion (n=289, 94.8%) while (n=16, 5.2%) were not part of religion. In addition, some of the participants considered themselves both religious and spiritual. Furthermore, some participants viewed themselves, as religious only and other participants reflected that they which was only spiritual. A previous study done by Chandramohan (2013) found that belief and faith conceptualized as a Godlike inspiring force which is embedded in spirituality which can be experienced inwardly or outwardly as interconnectedness with others, God or Higher Power. It is established as endowing, reformation and emancipating. Chandramohan (2013) reasons that most researchers view spirituality as not restricted to religious connection and practices thus including meaning, purpose and connection with the self and other, the Universe and definitive reality.

In the present study, the emergence of believing and having faith in God or higher power has been considered as the important aspect of the inner self and family life. Thus, the findings of the current study are consistent with those of Roger and Hatala (2018) who found that that religion and spirituality are multidimensional concepts. Consequently, it could be expected that different denominational groups, certain individuals, or exact characteristics of religious or spiritual life seemed to interact in distinct ways with different aspects of health and chronic illness conditions. The findings support the position of the World Health Organization (2001) who indicates that religion and spirituality seem to be related in order to help people establish their connection with a divine power. This may be explained by the expressions of the adults living with chronic diseases when they shared the importance of church and mosque.

The findings of the study revealed that religious occupations such as daily prayer and reading the bible appeared as enablers of the adults living with chronic diseases to cope with their circumstances. This result may be explained by the fact that the participants perceived the religious occupations as facilitators of connections with family and God. Adding to this,

(Jors, Büssing, Hvidt & Baumann, 2015). explains that several reasons could lead to why adults living with chronic illness tend to read their bible and engage in prayer on a daily basis. Firstly, the findings could be explained by the importance of disease-centered prayer utilised in order to improve the physical health and state of mind of adults living with chronic diseases so that they may enhance their self-management. Another possible reason for this is that prayers could be linked to assurance-centered prayers whereby the adults living with chronic diseases felt that even in the face of diseases and wrongdoings, God provided them with protection, hope, and strength. This is supported by the findings of the present study in theme two and three, which highlighted gratitude and forgiveness as part of assurance-centered prayers. Another possible alternative reason that could explain the use of prayer by adults living with chronic diseases is God-centered prayer that facilitated the relationship with God whereby adults living with chronic diseases engage in worship and reflecting on and experiencing God's presence in their lives (Jors et al., 2015). In addition, the World Health Organization (2001) states that people engage in religious or spiritual activities such as attending church, temple, mosque or synagogue, praying or chanting for religious purpose and spiritual contemplation.

The results of the present study indicate that the adults living with chronic diseases were in agreement with the importance of praying with someone (M=2.55; SD=0.61); someone prays for them (M=2.63; SD=0.54) and turn to Higher Presence (M=2.68; SD=0.58). These findings corroborate with Harvey and Silverman (2007) and Jors et al. (2015) possible reasons related to others-centered prayers including family, friend, health professionals and others. The findings of the current study reported that the inter-connectedness with God seemed to create spiritual calmness and peace within the inner self of the adults living with chronic diseases, so that they may gain their inner strength and courage for better health,

well-being and quality of life. Furthermore, the these findings are in line with O'Toole and Ramugondo (2018) and Linda, Klopper and Phethlu (2015) who indicated that people enhance their hope, aspiration and meaning of life by having relationship with God. This could mean that the adult living with chronic diseases were engaging in the spiritual and religious activities in order to improve their self-fulfilment.

5.2 Spirituality in adults living with chronic diseases

The findings of this study showed that there were positive aspects of spirituality that were experienced by the adults living with chronic diseases. Across all the themes that emerged in phase two of the qualitative results, it has been noted that spirituality appeared as a coping mechanism that has been used by adults living with chronic diseases. These findings can be explained in part by the number of previous studies which indicate spirituality seem to be related to physical, social, emotional and functional well-being of adults living with chronic diseases (Roger & Hatala, 2018; Jors et al., 2015; Mthembu et al., 2015).

In theme three (Spiritual experiences through the journey of life), the findings of the current study highlight that adults living with chronic diseases were of the opinion that caring for oneself requires having a positive mind-set. This finding could be explained by the quantitative results of phase one that were part of the spiritual needs particularly existential (reflection/meaning): to reflect on one's previous life (*M*= 2.30; *SD*=0.65), to dissolve open aspects of one's life (*M*=2.21; *SD*=0.62) and to find meaning in illness and/or suffering (*M*=2.27; *SD*= 0.71). Therefore, the current study indicated that self–reflections appeared to be an enabler that assisted the adults living with chronic diseases to cope with their experiences that influenced their positive health and wellbeing as shared by participants (Bibi

and Haley) in theme one “Trying to live healthy by accepting my chronic illness”. The results are in line with that of the study conducted by Roger and Hatala, (2018) who found that spirituality and religion were used as a coping mechanism of patients living with cancer. It is evident that spirituality and religion seem to improved self-esteem, quality of life, sense of meaning/purpose, sense of hope, as well as emotional comfort illnesses of adults living with chronic illness conditions (Roger & Hatala, 2018).

The most striking result that emerged from the data in the two phases of the present study is that social and family well-being appeared as an important element that created a sense of connectedness and support among adults living with chronic illness and their families. From the health related quality of life data, it is apparent that the participants were in agreement of the following statements: my family has accepted my illness (*M*=3.15, *SD*=1.33); I am satisfied with family communications about my illness (M=2.81, *SD*=1.50); *I feel close to my partner* (or the person who is my main support) (M=2.93, *SD*=1.59). Adding to this, the findings from the additional concerns of spiritual needs among adults living with chronic illness indicate that they were in agreement with the following statements: to feel connected with family (*M*=2.6, *SD*=0.56); for being complete and safe (*M*=2.56, *SD*=0.56) and to receive more support from your family (*M*=2.65, *SD*= 0.54). These findings are consistent with the findings in theme three the spiritual experiences through the journey of life. It is evident in Felicity shared experience *“I’ve got good support from my husband. He is supporting me with anything, assists me, and then I have a grandchild there who is 24 he is working. Sometimes he is off. Like this morning he said, ma, you can go on, I will clean the whole house, so I did nothing. He is busy cleaning the house. They’re very supportive”.*

The present findings suggest that there is a need for spiritual care among families and the broader community. This finding provides evidence of what Haley experienced "*I'm going to meet the truck and off load again. Then the community comes to stand here and I will hand over the food parcels to the elderly*". It is evident that creating supportive environments and networks within the communities for the adults living with chronic illness and their families resonate with the elements and attributes of spirituality as highlighted in theme three. The present findings also support Roger and Hatala's (2018) study which concluded that positive relationships exists between religion, spirituality, and health promoting practices among those living with chronic illnesses. This could be explained with the well-being need of intrinsic need and responsibility to care for and contribute to the well-being of others (Hammell, 2017).

5.3 Relationship between spirituality and Health related quality of life

The findings of this study revealed that there is a strong relationship between spirituality and health related quality of life. These findings corroborate with Büssing and Koenig (2010) who found that the spiritual needs of adults living with chronic diseases could be in the direction of either positive or negative relationship variables with regard to their understanding of their view of their illness. In addition, these relationships could be explained by the findings that emerged in theme one of phase two "trying to live a healthy lifestyle by accepting my chronic illness". Furthermore, the present study findings that emerged from theme one suggests that the notion of acceptance as well as insight into understanding of adults living with chronic illness holds fundamental importance in their coping and self-management. These factors may explain the relatively good correlation between spiritual needs to find meaning in illness and/or suffering and health related quality of life of the quantitative phase of this study: physical well-being, I feel ill (.173**); emotional well-being, I worry about dying (.140*)

and additional concerns my life has been productive (.167*), I have a sense of purpose in my life (0.165*), I am able to reach deep down into myself for comfort (.162*), I have a sense of harmony within myself(0.181**), I find comfort in my faith and spiritual belief (.186**),I find strength in my faith or spiritual beliefs (0.160*) and my illness has strengthened my faith or spiritual beliefs (.227**). It is evident as highlighted in both quantitative and qualitative phases within the study once acceptance and understanding has taken place the adult living with chronic diseases now is able to make better healthy choices, manage pain and cope with stressors accompanied by social life as well as difficulty engaging in daily occupations. This is supported by the study of Stojković et al. (2012) whose research found that there were positive relationships between spirituality, religion, health and quality of life. In addition, the study reported that faith had a significant influence on the acceptance of the disease in chronic patients living with chronic illness. Thus, Hammell (2017) concurs that engaging in spiritual practices tend to contribute to emotional self-care.

The current study found that there was a relationship between physical well-being and religious spiritual needs. Furthermore, pain (r = .133*) was found to be related to coping with chronic illness. These relationships may partly be explained by adults living with chronic diseases being forced to spend time in bed (r = .139**). These results are in agreement with Nita's experience that showed that "*we are being taught also how to control the pain and stuff, I take it step by step, time by time*". It can thus be suggested that adults living with chronic illness who experience chronic pain should be assisted with strategies that assist them to cope with their pain.

The results of this study show that there was a relationship between emotional well-being and religious spiritual needs. These could be explained by being satisfied with how the adults living with chronic illness is coping (r=.224**) with their conditions. These findings agree with the finding of Roger and Hatala (2018) who found that "spiritual and religious coping

were found to be mechanisms that provide some patients with a sense of purpose and meaning, to cope with emotional and physical difficulties" (p33). This is further supported by Felicity's experiences who shared that "*I achieved a lot in life, but as this guy says, there are still things that I want to achieve in my life, and I still believe and trust it's going to come*". These results are consistent with the theory of Polatajko et al. (2007) that accentuate the importance of spirituality in relation to affective in the Canadian Model of Occupational Performance and Engagement.

On the question of the relationship between emotional wellbeing and religious spiritual needs, this study found that adults living with chronic illness were worried about death and life after death (r=.156*). A possible explanation for this might be that adults living with chronic diseases appeared to be concerned about death as shared by Gloria *" I can't say life after death, what I'm feeling, because maybe ... look I'm dead already, so how am I going to know what is my life going to be after death*". Therefore, Gloria further suggested that they should pray and walk on the right path.

In this study, relationships were found between functional well-being and spiritual needs amongst adults living with chronic illness. Furthermore, it was found that there was an association with enjoying the things they used to do for fun (r= .219**). Another association was being content with the quality of their life (r=.199**). It was evident in the present study that spiritual needs were related to the concerns of adults living with chronic illness and health related quality of life. This is supported by the fact that adults living with chronic diseases found comfort in their faith or spiritual belief (r=.330**). Another relationship was that they found strength in their faith or spiritual belief (r=.374**). Moreover, the adults living with chronic illness felt that their illness was strengthened by their faith or spiritual believe (r= .336**). These findings of the study support evidence from the qualitative results of phase two. As highlighted by the three adults living with chronic diseases who shared that

"*He gives you the strength to get out of that bed every day*" (Nur), "*The older you become, the stronger you become. God gives you the strength to carry on*". (Haley) and "*I think it come from God to give you strength*" (Sifiso).

It has been found that there were relationships between actively giving of spiritual needs and social/family well-being of health related quality of life among adults living with chronic illness. The results indicated that there were a relationship between feeling close to their friends (r=.127*), their life has been productive (r=209**) and feeling a sense of purpose in their life (r=.322**). The findings are in line with theme three of the qualitative phase two of the study which highlighted the importance of a sense of community involvement and sharing with the community. In accordance with the present results, a previous study by Mthembu, Wegner and Roman (2017a) has demonstrated that spirituality is one of the important elements that connect community members. The current study highlighted that participants felt that they need to participate in meaningful and purposeful activities such as supporting their neighbours and giving back to their community. This could be a possible explanation for a sense of community.

5.4 Relationship between spirituality and Occupational Balance

It is evident from the findings that there was a relationship between spirituality and occupational balance. In reviewing the literature, data was found on the relationship between spirituality and occupation (Wilding, 2007). In addition, Wilding (2007) supports Polatajko et al. (2007) that spirituality is a form of being that provides the meaning that underpins doing.

From the findings of the current study, it was found that there were relationships between spiritual needs and engaging in a variety of activities such as praying with someone (-.148*), to participate in religious ceremonies (.218**), and to pass on your life experiences (-.141*).

This study produced results which corroborate the findings of a great deal of the previous work in WHO (2001) and Wilding (2007) which highlighted the importance of engagement in spiritual occupations such as prayer, meditation and worshipping. Consistent with the second theme (The things we used to do are now challenging), this research found that adults living with chronic diseases reported engaging in daily prayer, exercise, rest, sleep and taking medication. A possible explanation for these results may be that adults living with chronic illness received benefits from engaging in occupations that facilitate and promote health and well-being. The findings of the study provide evidences that engaging in meaningful and purposeful occupations such as prayer and exercise seemed to be practiced by adults living with chronic diseases in order to cope with their chronic condition. The CMOP-E by Polatajko et al. (2007) supports that persons are embedded in unique, external, social, cultural, institutional and physical environments that are influenced by spirituality. Thus, the adults living with chronic diseases could engage in variety of activities because spirituality seemed to be the motivating force that enables safe and satisfying engagement and performance in occupations.

It has been indicated that taking care of oneself appear "as an essentially occupational endeavour that may be accomplished through the help of others" (Hammell, 2017, p. 211). Accordingly, one interesting finding is that adults living with chronic diseases engage in collective occupations in their communities and families. According to Adams and Casteleijin (2014), collective occupation is the interactions between the occupations of two or more individuals, which appear to shape the occupations of all the individuals. From the findings of the study in theme three (Spiritual experiences through the journey of life), it was evident that the adults living with chronic illness engage in collective occupations such as facilitating exercise groups, running of soups kitchens as well as coaching soccer with the children in their communities. This result may be explained by the definition of Pickens and Pizur-

Barnekow (2011) which states that the nature of engagement in collective occupation involve aspects of shared physicality, shared emotionality , and shared intentionality, embedded in shared meaning. The World Health Organization (2001) and Polatajko et al. (2007) support the collective occupations, as they promote community, social and civic life of the citizens. In relation to CMOP-E, the findings of the current study support the role of individual and societal activities that enable social networks and capital. This could be supported by Bayat (2005) explanation of social capital as part of building reciprocal relationship and trust and how people interact over time within a space. Therefore, the findings of the current study are in agreement with Hammell (2017) who indicates that people have a need to experience a sense of belonging and connectedness to families, friends, and communities as well as spiritual traditions.

In contrast to the relationship between spiritual needs and occupational balance, however, there was evidence of occupational imbalance as one of the outcomes of occupational in justices experienced by adults living with chronic illness. The findings of previous studies support the findings of the current study about occupational demands in balancing daily occupations which appeared to be a challenge and pressure, as well as psychologically making it difficult to achieve (Eckelman, Bazyk & Bazyk, 2013; Stamm, lovelock, Stew, Nell, Smolen, Mchold, Johnson & Sadlo, 2009; Macdonald, Dietrich, Townsend, Li, Cox & Backman, 2012). In the second theme (the things we used to do is now challenging), adult living with chronic illness shared that their occupations has become demanding as expressed by Sifiso "*Even me, I'm working on the garden, but now I cannot manage to work in the gardens, because I got no hand to help me*".

In addition, the finding in relation to paid work and maintaining a job was very difficult and challenging because they were no longer able to meet the production speed expected of them

to perform. Adding to, adults' bodies seemed to struggle to cope with the pressures and demands due to the pain, discomfort and stiffness, and shortness of breathe experienced by adults living with chronic disease. The findings suggests that patients find it challenging to maintain paid work as well as other occupations not necessarily related to paid work which was consistent with the finding of (Stamm et al., 2009). A possible explanation for this might be that occupational balance does not necessitate being engaged in paid work but meaningful and purposeful activities.

CHAPTER SIX

CONCLUSION AND RECOMMENDATIONS

6 Introduction

In this chapter, a summary of the study in reference to its objectives and the study conclusion is presented. Recommendations from this study that focused on the relationship between spirituality and health related quality of life and occupational balance are formulated.

6.1 Conclusion

The interest of spirituality in adults with chronic diseases has been recognized as a core element of human occupation, health related quality of life and well-being. However, little is known about the relationship between spirituality, health-related quality of life and occupational balance among adults with chronic diseases in the Western Cape, South Africa. Clinicians often feel ill equipped to be present to the suffering of patients and the overwhelmingly complicated social issues associated with care for patients with complex chronic issues and diseases. This study may contribute to the body of knowledge of occupational therapy regarding the relationship between spirituality, health-related quality of life and occupational balance among adults with chronic diseases. Incorporation of health promotion and the Canadian Model of Occupational Performance and Engagement in practice seemed to be appropriate approaches for enhancing the well-being, quality of life and occupational balance of adults with chronic diseases. The research questions presented in chapter one were addressed in two phases. In phase one, the research question was posed "How does spirituality relate to health-related quality of life and occupational balance of adults with chronic diseases?" Furthermore, the second phase addressed "What are the

perceptions of adults with chronic diseases regarding the factors determined in phase one regarding the relationship between spirituality, health-related quality of life and occupational balance?" Therefore**,** the aim of the study was to examine the relationship between spirituality, health-related quality of life and occupational balance from the perspectives of adults living with chronic diseases.

6.2 The objectives of the study were:

1. To examine the perspectives on spirituality of adults living with chronic diseases
2. To examine the perspectives on health related quality of life of adults living with chronic diseases
3. To examine the perspectives on occupational balance of adults living with chronic diseases
4. To determine the relationship between spirituality and health related quality of life among adults with chronic diseases
5. To determine the relationship between spirituality and occupational balance among adults with chronic diseases
6. To explore and describe the perceptions of adults with chronic diseases regarding the relationship between spirituality, health related quality of life and occupational balance.

The objectives of the study are discussed to make the conclusion regarding the relationship between spirituality, health related quality of life and occupational balance.

Objective 1: The perspectives on spirituality of adults living with chronic diseases was divided into four dimensions namely; religious, inner peace, existential, actively giving and additional concerns. The findings in relation to the religious dimension indicated that adults

living with chronic diseases agreed that someone prays for them (*M*=2.63, *SD*= 0.54), to higher presence (God/Allah) (*M*=, 2.68, SD= 0.58) to participate at a religious ceremony (*M*=2.51, *SD=0.65*) and to pray with someone (*M*=2.55, *SD*=0.61). Concerning the inner peace dimension, it has been highlighted that inner peace (*M*=2.42, *SD*=0.62) was an element of adults living with chronic diseases. In addition, it was found that turning to someone in a loving attitude (*M*=2.40, *SD*= 0.65) was acknowledged by the participants. Regarding the existential dimension, of forgiving someone from a distinct period of one's life (*M*=2.49, *SD*=0.64), it has been found to be a better way to cope with challenges of living with chronic diseases. Similarly, adults living with chronic diseases perceived reflections on previous life (M=2.30, *SD*=0.65) as important. It was agreed that talking with someone about the question of meaning in life (M=2.56, *SD*=0.65) was essential to better health and well-being. Furthermore, the actively giving dimension was related to passing on life experiences to others (*M*=2.53, *SD*=0.63) and to be assured that their life had was meaningful and had value (*M*=2.56, *SD*=0.59). Lastly, additional concerns related by the participants was to receive more support from their family (*M*=2.65, *SD* =0.54) and to feel connected to family (*M*= 2.64, *SD* =0.56).

Objective 2: The perspectives on health related quality of life of adults living with chronic diseases highlighted elements of physical well-being, social and family well-being, emotional well-being, functional well-being and additional concerns. In relation to physical well-being adults living with chronic illness reported that they experience pain (*M*=2.71, *SD*=1.53) and feel ill (*M*=1.81, *SD*=1.52). Furthermore, in relation to social and family well-being, that they felt close to their partners (*M*=3.15, *SD*=1.33) and received support from their family and friends (*M*=1.76, *SD*=1.74). In addition, with regards to emotional well-being of adults living with chronic illness were in agreement that they were not worried about dying and were satisfied with how they were coping with their illness. In connection to functional well-being,

participants reported that they were enjoying their life (*M*=2.56, *SD*=1.47) and were content about their quality of life (*M*=2.26, *SD*=1.64). There were additional concerns about having a reason for living (*M*=3.52, *SD*=1.05), feeling a sense of purpose in life (*M*=2.72, *SD*=1.36*)*, finding comfort in their faith or spiritual belief (*M*=3.46, *SD*=1.05*)* and finding strength in their faith or spiritual belief (*M*=3.39, *SD*=1.10*).*

Objective 3: With regards to the perspectives on occupational balance of adults living with chronic diseases, it was found that adults living with chronic illness agreed that they engaged in a variety of activities. However, chronic diseases have been found to influence the health and everyday activities of adults living with chronic diseases (*M*=2.34, *SD*=0.66). The findings of the study support the need of promoting engagement in occupations as part of the functional well-being of adults living with chronic diseases.

Objectives 4, 5 and 6 addressed the relationship between spirituality and health related quality of life and occupational balance among adults with chronic diseases. Spirituality was found to be connected to health related quality of life for adults living with chronic illness. The findings highlighted finding inner peace with one's condition was related to physical, social/family, emotional, functional well-being and additional well-being concerns. Furthermore, spirituality was related to occupational balance as the adults indicated that they were participating in a variety of activities such coaching, facilitating social exercise groups, running of soup kitchens and handing out parcels within their community. Spirituality was related to engaging in daily prayer, reading bible and worshipping God. Engaging in co-occupations enabled the adults with chronic illness to cope with their previous and current circumstance. In addition, this facilitated meaning and purpose within their lives so that they can use their occupational choices based on capabilities. In contrast, there were occupational demands that might have influenced the adults living with chronic disease from engaging in

those satisfying activities. Sharing, passing and learning through life experiences from family and friends appeared as enablers of actively giving of the self and to others.

6.3 Limitations

The findings in this report are subject to at least three limitations. First, the research design used in this study appeared to be lengthy and time consuming for data collection and analysis for both phases. Secondly, generalisability of these results is subject to certain limitations and therefore one needs to be cautious when interpreting the results. For instance, the results may not be inferred to other adults living with chronic diseases, however, only apply to the participants who were part of the study. Secondly, the lack of large number of male participants in the sample adds further caution regarding the generalisability of these findings. Thirdly, the study only took place in one primary health care centre. Lastly, the study did not evaluate how clinicians integrate spirituality in occupational therapy services.

6.4 Recommendations

The relationship between spirituality and health related quality of life and occupational balance that was assessed in this thesis provides findings that point out certain implications for practice. In order to enhance an effective occupational therapy services for adults living with chronic diseases, the following recommendations are deemed necessary for occupational therapy practice, education, policy and further research.

6.4.1 Occupational therapy continuing professional development

It has emerged from the study that spirituality was related to health related quality of life and occupational balance. This particular research finding also points to the need for clinicians in

occupational therapy practice to be trained about the importance of spirituality in adults living with chronic diseases. According to the World Health Organization (2001), spiritual and religious activities are considered as motivating factors that enable human beings to find hope in coping with difficult circumstances. It is recommended that continuing professional development opportunities focussing on spirituality in occupational therapy practice be implemented by expert in the field of spirituality and occupational therapy.

6.4.2 Occupational therapy education

Currently, few studies investigate the development of guidelines to integrate spirituality and spiritual care in occupational therapy education. Moreover, more emphasis should be made in occupational therapy education about spirituality in relation to health related quality of life and occupational balance. It is recommended that the occupational therapy educators should consider scaffolding spirituality in occupational therapy curricula through all the year levels. Furthermore, it is recommended that the Occupational Therapy Association of South Africa should play a role in monitoring that spirituality integrated within occupational therapy curricula.

6.4.3 Policy

A key policy priority should therefore be to plan for the long-term integration of spirituality as part of continuum of care and International Classification of Functioning, Disability and Health. The World Health Organization (2001) states that religious and spirituality form part of humanistic approach. It is recommended that spirituality should be integrated as part of the continuum package of care within Department of Health as well as in the rehabilitation policy framework.

6.4.4 Further research

Further research should be undertaken to explore how spirituality relate to occupational balance in the field of occupational therapy practice. Another possible area of future research would be to investigate how spirituality influences occupational engagement of male adults living with chronic disease.

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Appendices

Appendix 1: Ethics clearance letter

UNIVERSITY of the WESTERN CAPE

DEPARTMENT OF RESEARCH DEVELOPMENT

14 January 2016

To Whom It May Concern

I hereby certify that the Senate Research Committee of the University of the Western Cape approved the methodology and ethics of the following research project by:
Ms Y Parker (Occupational Therapy)

Research Project:	The relationship between spirituality, health-related quality of life and occupational balance among adults with chronic diseases.
Registration no:	15/7/78

Any amendments, extension or other modifications to the protocol must be submitted to the Ethics Committee for approval.

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

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

Private Bag X17, Bellville 7535, South Africa
T: +27 21 959 2988/2948 . F: +27 21 959 3170
E: pjosias@uwc.ac.za
www.uwc.ac.za

Appendix 2: Permission letter from Department of Health

Western Cape Government
Health

STRATEGY & HEALTH SUPPORT
Health.Research@westerncape.gov.za
tel: +27 21 483 6857; fax: +27 21 483 9895
5th Floor, Norton Rose House,, 8 Riebeek Street, Cape Town, 8001
www.capegateway.gov.za)

REFERENCE: WC_2016RP50_627
ENQUIRIES: Ms Charlene Roderick

Delft Main Rd
The Hague
Cape Town
7100

For attention: **Ms Yasmeen Parker**

Re: **THE RELATIONSHIP BETWEEN SPIRITUALITY, HEALTH-RELATED QUALITY OF LIFE AND OCCUPATIONAL BALANCE AMONG ADULTS WITH CHRONIC DISEASES.**

Thank you for submitting your proposal to undertake the above-mentioned study. We are pleased to inform you that the department has granted you approval for your research.
Please contact the following people to assist you with any further enquiries in accessing the following sites:

Delft CHC **Sheron Forgus** **Contact No: 021 954 2237**

Kindly ensure that the following are adhered to:

1. Arrangements can be made with managers, providing that normal activities at requested facilities are not interrupted.
2. Researchers, in accessing provincial health facilities, are expressing consent to provide the department with an electronic copy of the final feedback (**annexure 9**) within six months of completion of research. This can be submitted to the provincial Research Co-ordinator (Health.Research@westerncape.gov.za).
3. In the event where the research project goes beyond the *estimated completion* date which was submitted, researchers are expected to complete and submit a progress report (**Annexure 8**) to the provincial Research Co-ordinator (Health.Research@westerncape.gov.za).
4. The reference number above should be quoted in all future correspondence.

Yours sincerely

AS HAWKRIDGE.

DR A HAWKRIDGE
DIRECTOR: HEALTH IMPACT ASSESSMENT
DATE: 12/4/2016.
CC:

Appendix 3: Permission Letter FACIT Sp-12

FACIT.org • FACIT trans

PROVIDING A VOICE FOR PATIENTS WORLDWIDE

FUNCTIONAL ASSESSMENT OF CHRONIC ILLNESS THERAPY (FACIT) LICENSING AGREEMENT

April 21, 2015

The Functional Assessment of Chronic Illness Therapy system of Quality of Life questionnaires and all related subscales, translations, and adaptations ("FACIT System") are owned and copyrighted by David Cella, Ph.D. The ownership and copyright of the FACIT System - resides strictly with Dr. Cella. Dr. Cella has granted FACIT.org (Licensor) the right to license usage of the FACIT System to other parties. Licensor represents and warrants that it has the right to grant the License contemplated by this agreement. Licensor provides to ***Yasmeen Parker*** *the licensing agreement outlined below.*

This letter serves notice that **Yasmeen Parker** ("INDIVIDUAL") is granted license to use the **English** version of the **FACIT-Sp-12** in one study.

This current license extends to (INDIVIDUAL) subject to the following terms:

1) (INDIVIDUAL) agrees to provide Licensor with copies of any publications which come about as the result of collecting data with any FACIT questionnaire.

2) Due to the ongoing nature of cross-cultural linguistic research, Licensor reserves the right to make adaptations or revisions to wording in the FACIT, and/or related translations as necessary. If such changes occur, (INDIVIDUAL) will have the option of using either previous or updated versions according to its own research objectives.

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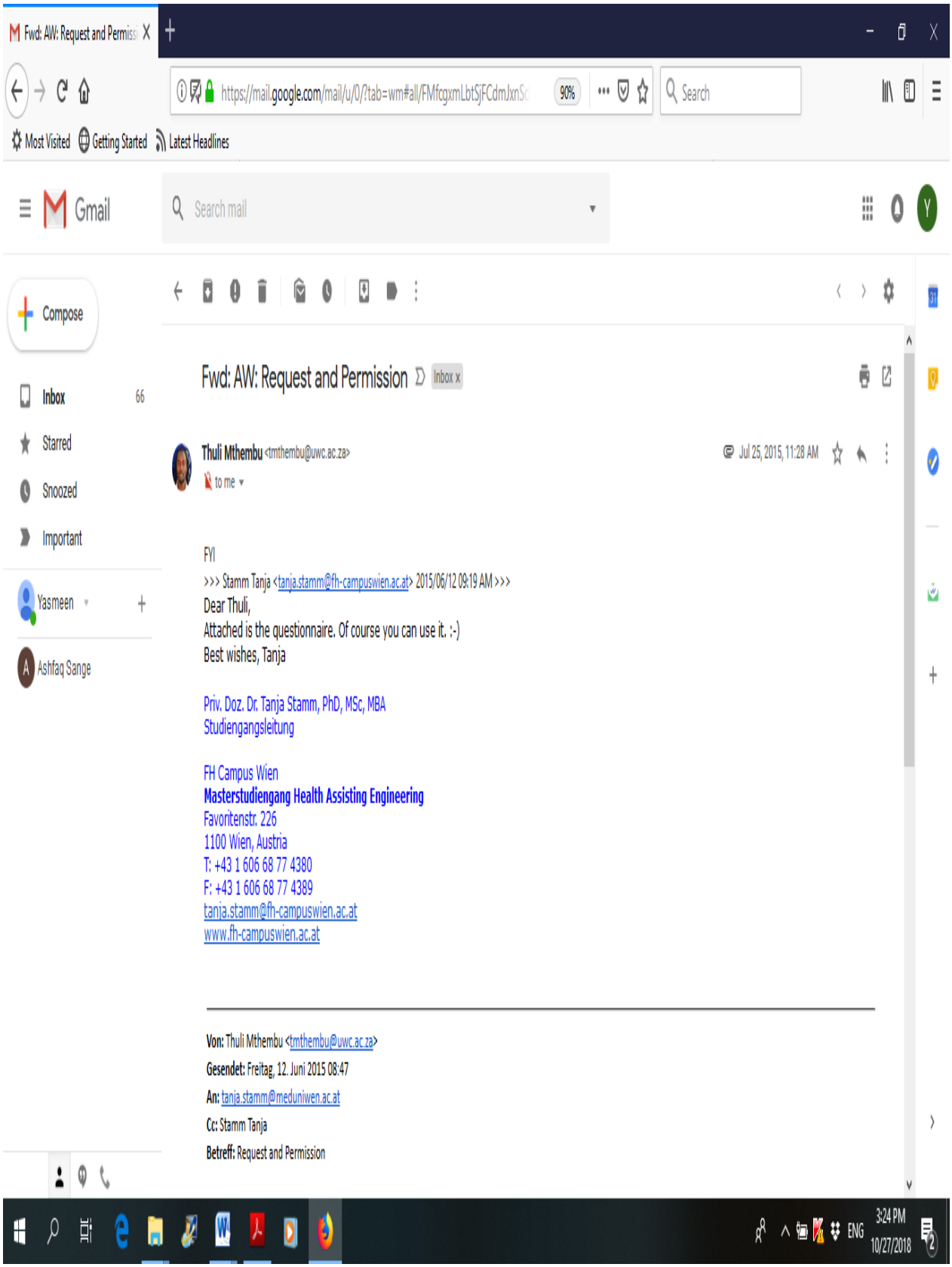
5) This license is only extended for use on the internet on servers internal to (INDIVIDUAL). This FACIT license may not be used with online data capture unless specifically agreed to by Licensor in writing. Such agreement will only be provided in cases where access is password protected.

www.FACIT.org 381 South Cottage Hill, Elmhurst, IL, USA 60126 FAX: + 1.630.279.9465 information@FACIT.org

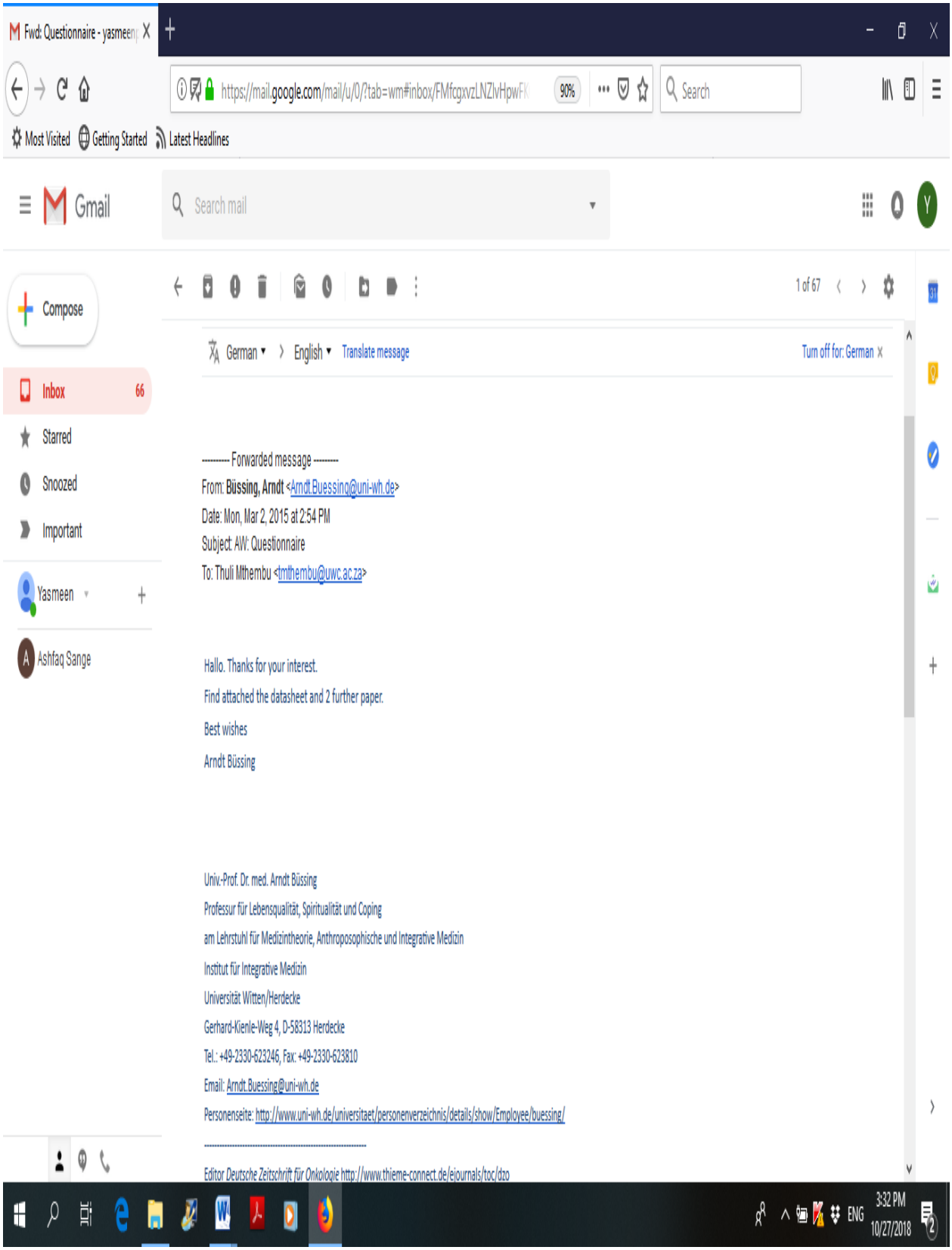
6) Licensor reserves the right to withdraw this license if (INDIVIDUAL) engages in scientific or copyright misuse of the FACIT system of questionnaires.

7) There are no fees associated with this license.

Appendix 4: Permission letter for Occupational Balance Quest



Appendix 5: Permission letter for Spiritual Needs Questionnaire



Appendix 6: Permission Letter

UNIVERSITY OF THE WESTERN CAPE

Private Bag X 17, Bellville 7535, South Africa
Tel: +27 21-9340 Fax: 27 21-959 9359
E-mail: 2212852@myuwc.ac.za

Delft Community Health Care Facility
Delft Main Road
7100

Dear Sir/Madam

REQUEST FOR PERMISSION TO CONDUCT A RESEARCH STUDY WITH CLIENTS AT DELFT COMMUNITY HEALTH FACILITY

As part of the postgraduate Masters Science in Occupational Therapy (OT) course at the University of the Western Cape (UWC), I am required to conduct a research study. As an OT Masters student, I wish to obtain permission to conduct research adult living with chronic diseases.

The aim of the study is to examine the relationship between spirituality, health-related quality of life and occupational balance from the perspectives of adults living with chronic diseases. The significance of this study therefore exists in the fact that it will contribute to the professional development of researchers and clinicians working in practice as well as education. It will improve occupational therapy specific therapeutic programs and promote evidence based practice.

In order to gain sufficient data for our research I aimed to collected data using questionnaire and conduct four focus groups, for the duration of 45- 60 minutes.

Please find my research proposal attached for a more detailed account of our research topic and of the research process. I would be pleased if permission could be granted for me to conduct this research with adult living with chronic accessing health services at the facility.

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

NAME: Mr Thuli Mthembu
DEPARTMENT of occupational therapy
CONTACT +27 21-959 9340
EMAIL: tmthembu@uwc.ac.za

NAME: Dr. Lucia Hess-April
DEPARTMENT of occupational therapy
CONTACT 021 9593929
EMAIL: lhess-april@uwc.ac.za

Kind regards

Yasmeen Parker

Appendix 7: Information Sheet

UNIVERSITY OF THE WESTERN CAPE

Private Bag X 17, Bellville 7535, South Africa
Tel: +27 21-9340 Fax: 27 21-959 9359
E-mail: 2212852@myuwc.ac.za

INFORMATION SHEET

Project Title: The relationship between spirituality, health-related quality of life and occupational balance among adults with chronic diseases

What is this study about?

This is a research project being conducted by Yasmeen Parker at the University of the Western Cape. We are inviting you to participate in this research project to provide us an understanding of spirituality, health-related quality of life and occupational balance among adults with chronic diseases. The purpose of this research project is to examine the relationship between spirituality, health-related quality of life and occupational balance among adults with chronic diseases.

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

You will be asked to participate in survey and focus groups concerning the spirituality, health related quality of life and occupational balance. Participants in this study will be requested to participate in survey and focus groups which will be held in the Health facility for the duration of 45 to 60 minutes.

Would my participation in this study be kept confidential?

I will keep your personal information confidential. To help protect your confidentiality, the information you provide will be totally private; no names will be used so there is no way that you will be identified as a participant in this study and pseudo names will be used. The information will be treated with anonymity and confidentiality. All the data in the self-

administered questionnaire and focus groups will be given to the supervisor and kept in the occupational therapy department which will ensure for confidentiality and privacy. If I write a report or article about this research project, your identity will be protected. This study will use focus groups and the extent to which your identity will remain confidential is dependent on participants' in the Focus Group maintaining confidentiality.

What are the risks of this research?

Any research has risks but in this research I will try to minimize the risk of being harmed in any way. If there are painful memories of experiences or experiences which may evolve during the research process, I will refer you for the necessary support. All human interactions and talking about self or others carry some amount of risks. I 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.

What are the benefits of this research?

The results of the study could have implications for (1) students (2) educators (3) clinicians. The results will have implications on quality of life, health and wellbeing of adults living with chronic diseases. It could also help in coping with stressful circumstances in life.

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 take part in this study. If you decide to participate in this research, you may stop participating at any time. If you decide not to participate in this study or if you stop participating at any time, you will not be penalized or lose any benefits to which you otherwise qualify.

What if I have questions?

This research is being conducted by Yasmeen Parker in the department of occupational therapy at the University of the Western Cape. If you have any questions about the research study itself, please contact Yasmeen Parker or Dr Thuli Mthembu (+27 21-959 9340, tmthembu@uwc.ac.za) and Dr. Lucia Hess-April (lhess-april@uwc.ac.za)

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 Shaheed Soeker

Dean of the Faculty of Community and Health Sciences:
Prof A. Rhoda
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.

Appendix 8: Consent Form

UNIVERSITY OF THE WESTERN CAPE

Private Bag X 17, Bellville 7535, South Africa
Tel: +27 21-959 9340, Fax: 27 21-959 9359
e-mail: 2212852@myuwc.ac.za

CONSENT FORM

Title of Research Project: The relationship between spirituality, health-related quality of life and occupational balance among adults with chronic diseases

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.

Participant's name……..

Participant's signature…….

Date……

Appendix 9: Focus Group Binding Form

UNIVERSITY OF THE WESTERN CAPE

Private Bag X 17, Bellville 7535, South Africa
Tel: +27 21-959 9340, Fax: 27 21-959 9359

e-mail: 2212852@myuwc.ac.za

FOCUS GROUP CONFIDENTIALITY BINDING FORM

Title of Research Project: The relationship between spirituality, health-related quality of life and occupational balance among adults with chronic diseases

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……

Appendix 10: Questionnaire

Part 1: Participant demographic details

Please complete the information requested below:

1. What is your age? (Years)

2. What is your Gender? (Please tick (√) the appropriate box)

☐Male ☐Female

3. What is your Race? (Please tick (√) the appropriate box)

☐African ☐White

☐Coloured ☐Indian

4. What is your marital status? (Please tick (√) the appropriate box)

☐Single ☐Married

☐Divorce ☐Separated

5. Level of Education (Please tick (√) the appropriate box)

☐Primary ☐Secondary

☐Tertiary

6. Economic level

☐ Disability grant ☐ pensioner

☐ 500 -2000 ☐ 6000-8000

☐ 10000-20000

7. Do you have a religion? (Please tick (√) the appropriate box)

☐Yes _Please indicate type of religion

☐No

a. Do you participate or attend any activities organized by your religious group?

If yes please indicate the frequency by ticking (√) the box which is the nearest to your answer.

☐More than once a week ☐Once a week

☐Once fortnight ☐Once a month

☐Occasionally (e.g. once a year or during religious activities) **☐Never**

b. If No, are you involved in any non- religious activities e.g. meditation, scriptural study group, prayer etc.? (Please tick (√) the appropriate box)

☐Yes **☐No**

8. Do you consider yourself (Please tick (√) the appropriate box)

☐Religious ☐Spiritual

9. Medical condition /Diagnosis:

Occupational Balance-Questionnaire (OB-Quest)

"Occupations" or "activities" refer to all the things that you do, including very simple things, such as bathing or getting dressed. The definition of "activities" includes professional actions, free-time and relaxation activities (such as reading or sleeping), as well as childcare and the support of dependents. Please put an 'x' next to the **most applicable** answer to each question.

1. Do you generally find your activities in your everyday life under-demanding?

I don't find my activities to be under-demanding	I find some of my activities to be under-demanding	I find most of my activities to be under-demanding
□	□	□

2. Do you generally find your activities in your everyday life over-demanding?

I don't find my activities to be over-demanding	I find some of my activities to be over-demanding	I find most of my activities to be over-demanding
□	□	□

3. Do you generally receive enough appreciation for activities in your everyday life?

I receive quite a lot of appreciation	I receive enough appreciation	I do not receive any appreciation
□	□	□

4. How often do you feel overstressed in your everyday life?

Never	Sometimes	Often
□	□	□

5. How much are your activities in your everyday life affected by your health?

Not at all	A little	Very much
□	□	□

6. Do you get enough rest?

I get enough rest	I get little rest	I get very little rest
□	□	□

7. Do you get enough sleep?

I get enough sleep	I get little sleep	I get very little sleep
□	□	□

8. Do you have sufficient variety of different activities that you do? For example, do you do a mixture of physical activities and more sedentary ones (where you are sitting down or staying still)? Or a mixture of creative activities and activities that are more routine for you?

I have a sufficient variety	I have a little variety	I have no variety at all
□	□	□

9. How well can you adapt your activities in your everyday life to changed living conditions, such as a changed state of health?

Very well	Badly	Not at all
□	□	□

10. How well can you adapt your activities in your everyday life to changed living conditions, such as a change of your professional life or employment status?

Very well	Badly	Not at all
□	□	□

Below is a list of statements that other people with your illness have said are important**. Please circle or mark one number per line to indicate your response as it applies to the <u>past 7 days</u>.**

	<u>PHYSICAL WELL-BEING</u>	**Not at all**	**A little bit**	**Some -what**	**Quite a bit**	**Very much**
GP1	I have a lack of energy	0	1	2	3	4
GP2	I have nausea.....	0	1	2	3	4
GP3	Because of my physical condition, I have trouble meeting the needs of my family.....	0	1	2	3	4
GP4	I have pain.....	0	1	2	3	4
GP5	I am bothered by side effects of treatment.....	0	1	2	3	4
GP6	I feel ill.....	0	1	2	3	4

GP7	I am forced to spend time in bed.....	0	1	2	3	4

	SOCIAL/FAMILY WELL-BEING	**Not at all**	**A little bit**	**Some -what**	**Quite a bit**	**Very much**
GS1	I feel close to my friends.....	0	1	2	3	4
GS2	I get emotional support from my family.....	0	1	2	3	4
GS3	I get support from my friends	0	1	2	3	4
GS4	My family has accepted my illness.....	0	1	2	3	4
GS5	I am satisfied with family communication about my illness	0	1	2	3	4
GS6	I feel close to my partner (or the person who is my main support)	0	1	2	3	4
Q1	*Regardless of your current level of sexual activity, please answer the following question. If you prefer not to answer it, please mark this box* ☐ *and go to the next section.*					
GS7	I am satisfied with my sex life.....	0	1	2	3	4

Please circle or mark one number per line to indicate your response as it applies to the <u>past 7 days</u>.

	EMOTIONAL WELL-BEING	**Not at all**	**A little bit**	**Some -what**	**Quite a bit**	**Very much**
GE1	I feel sad.....	0	1	2	3	4
GE2	I am satisfied with how I am coping with my illness	0	1	2	3	4
GE3	I am losing hope in the fight against my illness	0	1	2	3	4
GE4	I feel nervous	0	1	2	3	4
GE5	I worry about dying.....	0	1	2	3	4
GE6	I worry that my condition will get worse.....	0	1	2	3	4

	FUNCTIONAL WELL-BEING	**Not at all**	**A little bit**	**Some -what**	**Quite a bit**	**Very much**
GF1	I am able to work (include work at home).....	0	1	2	3	4
GF2	My work (include work at home) is fulfilling	0	1	2	3	4
GF3	I am able to enjoy life	0	1	2	3	4
GF4	I have accepted my illness	0	1	2	3	4
GF5	I am sleeping well.....	0	1	2	3	4
GF6	I am enjoying the things I usually do for fun.....	0	1	2	3	4
GF7	I am content with the quality of my life right now	0	1	2	3	4

Please circle or mark one number per line to indicate your response as it applies to the <u>past 7 days</u>.

	ADDITIONAL CONCERNS	**Not at all**	**A little bit**	**Some -what**	**Quite a bit**	**Very much**
Sp1	I feel peaceful.....	0	1	2	3	4
Sp2	I have a reason for living	0	1	2	3	4
Sp3	My life has been productive.....	0	1	2	3	4
Sp4	I have trouble feeling peace of mind.....	0	1	2	3	4
Sp5	I feel a sense of purpose in my life	0	1	2	3	4
Sp6	I am able to reach down deep into myself for comfort.....	0	1	2	3	4
Sp7	I feel a sense of harmony within myself	0	1	2	3	4
Sp8	My life lacks meaning and purpose	0	1	2	3	4
Sp9	I find comfort in my faith or spiritual beliefs	0	1	2	3	4
Sp10	I find strength in my faith or spiritual beliefs	0	1	2	3	4
Sp11	My illness has strengthened my faith or spiritual beliefs.....	0	1	2	3	4
Sp12	I know that whatever happens with my illness, things will be okay	0	1	2	3	4

Spiritual Needs (SpNQ)-21

During the last time, did you have the needs		Agreement		If YES How strong is this need?		
		No	Yes	some what	strong	Very strong
N2	To talk with others about your fears and worries?			1	2	3
N3	That someone of your religious community (i.e. pastor) cares for you?			1	2	3
N4	To reflect your previous life?			1	2	3
N5	To dissolve open aspects of your life?			1	2	3
N6	To plunge into beauty of nature?			1	2	3
N7	To dwell at a place of quietness and peace?			1	2	3
N8	To find inner peace?			1	2	3
N10	To find meaning in illness and/or suffering?			1	2	3
N11	To talk with someone about the question of meaning in life?			1	2	3
N12	To talk with someone about the possibility of life after death?			1	2	3
N13	To turn to someone in a loving attitude?			1	2	3
N14	To give away something from yourself?			1	2	3
N15	To solace someone?			1	2	3
N16	To forgive someone from a distinct period of your life?			1	2	3
N18	To be forgiven?			1	2	3
N19	To pray with someone?			1	2	3
N20	That someone prays for you?			1	2	3
N21	To participate at a religious ceremony (i.e. service)?			1	2	3
N22	To read religious / spiritual books?			1	2	3
N23	To turn to a higher presence (i.e. God, Allah, Angels, Oneness)?			1	2	3
N24	For being complete and safe?			1	2	3
N25	To feel connected with family?			1	2	3
N26	To pass own life experiences to others?			1	2	3
N27	To be assured that your life was meaningful and of value?			1	2	3
N28	To be re-involved by your family in their life concerns?			1	2	3
N30	To receive more support from your family?			1	2	3

Appendix 11: Interview guide Focus Group Discussion Interview guide

1. According to the data findings most people linked importance to spirituality, tell me is this true for all of you as well? What helped you through your process of recovery when you discovered you suffered a chronic illness?

2. Briefly describe or explain how your illness/ condition changed your quality of life living with chronic illness/condition?

3. Considering that we are expected to perform our daily activities can you describe what assisted you to carry out your daily tasks and would you say that having faith and being spiritual contributes to allowing you to achieve this?

4. From the questionnaires done most people reported that they are adapting very well with their activities of daily living, can you please tell me what assisted you to cope with the change state of your health condition? For those that feel that they coped badly can you also briefly tell me what hindered this?

5. Most also indicated that they find it difficult to return to work or will not consider alternative type of work, can you tell me whether balancing work and home has an impact on your quality of life living with chronic diseases?

5. What causes you not to sleep at night?

6. Many of you have indicated you have quite a bit of pain, can you describe to me what assists you to cope with the pain?

7. Briefly tell me the importance of accepting your condition/illness and having family and friends support when living with a health related chronic condition or illness?

8. Some indicated in the questionnaires that they not worried about dying or their condition getting worse, where some felt they are worried. Can you tell me has your faith and spirituality played a role in this acceptance?

9. Most people felt their faith or spiritual beliefs gave them comfort , strength as well as their illness was strengthened by their faith or spiritual beliefs, can you describe to me the why this is so ?

10. Seems that forgiving people and being forgiven is very important to people, can you tell me why and how it impacts your quality of life and spiritual aspects of your lives?

11. Tell me if you have experienced because of your physical condition that you have trouble meeting the needs of your family?

12. Briefly explain to me whether you are enjoying the simple pleasures in life, the things you used to do for fun?

13. Tell me are you all stressed? Briefly explain how have you been coping with your illness?

14. What drives you in life? What gives you meaning and purpose in life?

15. Briefly explain to me what gives one inner peace. What does this mean to you?

16. Explain whether there is an importance and significance to sit in a place that is quiet and peaceful.

17. Briefly explain whether you feel the need to share your own life experiences to others such as family, friends, neighbours etc.