+POST CARDS AND LETTERS FROM THE PAST: REFLECTIONS ON THEN AND ITS IMPACT UPON NOW.

Presentation Colloquium : Six Decades of Occupational Therapy in South Africa: One Elephant a Day. (In honour of Mr Jack Murray)University of the Free State, 15th and 16th May 2008.

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Introduction: On the 2nd of January 1976, approximately 32 years, 4 months and 15 days ago I packed up my old beige Ford Estcort with a couple of suitcases full of clothes and one or two boxes of trousseau odds and ends, the remnants of a wedding that never came to pass, and headed over the green and mountainous landscape of KwaZulu-Natal to the flat, beige, brown and blue skyd landscape of the Orange Free State. It was a long, cool trip as the plains had been flooded by enormous rains the day before and steam rose from the drying fields of sunflowers and mielies.

My heart was heavy with the sadness of leaving my beloved family, friends and Natal behind me. I was deeply anxious about starting a new vocation as lecturer in occupational therapy at a the University of the Orange Free State.I was equally worried about having to work together with Elna Muller who was to be the Head of Department. Elna had lectured me as a student in Pretoria and she and I had had several confrontations in my student days. My friends in Natal had laughed at the prospect of me going to the Free State and some even bet me I'd be back within a year. On arrival I was very lucky to have been given Lyn and Lex Visser's house to stay in until I found my own accommodation as they were overseas at the time.

It took me just about three months to get over the homesickness and to adapt to what was to become 4 and a half of the happiest and nicest years of my life. Ja, Vrystaters is enig in sy sort, within days of arriving various friends of Lyn and Lex invited me to dinners, picnics, shows and braais; new friends took me sailing and when I moved into my own little cottage in Milner Rd a few months later, I had friends delivering meals and flowers and love all day long.

Elna and I had no choice but to become friends and we ended up building a special bond during that time. But it wasn't long after she started that a handsome school principal by the name of Fritz Jooste, whom she had met some years before, paid very regular visits to her and within a year she and Fritz were married and he bustled her off to Krugersdorp. This meant that a replacement had to be recruited and so it was that Jock Murray was appointed as the new Head of Department. I was delighted, I had known Jock since our student days as my senior when I started training at Pretoria College. I remember having a wide-eyed, typical first year admiration for this dashing, dark haired senior student who was one of the few of us who also spoke English. So it was that I, still wet behind the ears, and Jock, worked together to get the first few years of training off the ground, with Lollie at the secretarial helm, we were also joined by other lecturers such as Santi and Madi. They were very special years and I regard Jock as a special mentor to me at that time. He was extremely patient and took particular care to lead and guide me into the newness of not only becoming a lecturer but starting a new course. It was largely this mentorship that made it possible for me to so much more easily take on the leadership of starting the new course at the University of Durban-

Westville, three and a half years later. Thank you Jock, it was truly a privilege working with you.

When I left I fulfilled the Free State prophesy that says " *jy huil as jy aankom in Bloem and jy huil weer as jy moet weg gaan".* Four and a half years later I packed up the contents of my cottage into a Stuttafords van, chucked my suitcases into the back of my little blue Alpha Romeo and cried all the way back to Durban. And still today when there's a rugby match on with the Cheetahs playing, it is the Cheetahs that I scream for, except of course if they are playing the Sharks!

Postcards and Reflections from then and now:

Today I am going to digress from the usual colloquium genre of presentation. As this is a particularly special occasion, I felt I wanted to do something different to the usual academic discourse, and rather turn it into a more aesthetic and personal one in which I am going to read to you some of the post cards and letters from my thesis which was a theoretical study that explored a range of conceptual arguments around the development of occupational therapy in South Africa and the effect of its particular history upon OT'S epistemology. It was an exploration of the journey of myself as an occupational therapist and professional educator at university, within an evolving profession, in a country as it moved from its apartheid history to an emancipated legal democracy.

As part of my data I used an auto-ethnographical technique in which I used my own experiences as an OT during part of this history, as some of the data. Using the metaphor of a journey, I placed this autobiographical information at strategic points within the thesis in what I referred to as "post cards" and "letters". They were either in the form of a collage of my memories or they were accounts of specific incidents in my history in OT in South Africa.

As they are not only of historical interest, they will also stir memories for many of you who are here today and especially for Jock so I am going to read you some of these postcards and letters in the form of a type of poetic prose, as it were, and where appropriate provide a brief commentary on some of them. But I think you will find that most if them speak for themselves. I would like it to be a sensual, provocative and emotional rather than an academic experience, so sit back, relax and allow yourselves to be stirred.

Postcard #2: Student years: Cadavers in Fancy Dress

I recall in my first year as a student occupational therapist, wet behind the ears and bubbling with naïve enthusiasm, how we were introduced to our cadavers for the first anatomy lesson. The dissecting hall was enormous, stretching from the front to the back wall along the whole of one side of the "BMW Gebou".. It was clinical and sanitised from top to bottom, the air pungent with the smell of formaldehyde. What seemed like rows and rows of stainless steel "plinths" stretched out before us, and upon each lay the half distinct shape of a human body wrapped in neatly folded white plastic sheeting. We too were all neatly robed in our starched white laboratory coats with our little box of prodders and

tweezers with which to prod and tweeze the various muscles, nerves, blood vessels and other bits of human tissue that our examinations would reveal to us. (We weren't allowed to dissect the corpses; this was done first by the medical students and as they dissected a segment, so we were allowed in after them to study what they had revealed, such as an arm or thorax or abdomen). I remember saying a little prayer asking God to help me to continuously respect the fact that I was dealing with a human body, albeit a dead one.

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

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

Extract from Letter#1 Student years continue into early post-graduate years.**……***As young students we did often sit around our glasses of wine, mugs of old brown sherry or coffee and discuss some of the more disturbing issues of apartheid, but for the most part I found myself complacently and comfortably cushioned within a world that had been orchestrated to ensure my well-being and which deliberately screened me from the reality of the situation, so that it became very easy to ignore that reality. In the early 70's like a "luislang" digesting the enormous meal that grotesquely distorts its body, the disturbing reality of what was happening around me eventually penetrated my, until then, comfort-zoned world. It was particularly after I had qualified and witnessed the discriminatory practices within the Health Services of those days that this awareness of the deeper and more terrible truth of what I was part and in the midst of, hit the stomach-pit of my conscience.*

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

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

Postcard #1 – Eartly years as lecturer at UDW - A personal reflection.

More than half of my life up to the present has been dedicated to the practice, development and teaching of occupational therapy in South Africa and now that this term is coming to a close, I have been drawn more and more into reflection upon my life within this vocation. In the early days it was a constant driving force to keep abreast of the struggles that intertwined like a huge knot of writhing snakes, pulling and twining and intertwining and separating. One moment suffocating, and the next causing me to gasp in excited amazement. One moment the ratatatatatat of gunshot, stifling smell of tear gas, bark of police dogs, scream of students, and shatter of breaking glass from rocks hurled in furious indignation, accompanied by the ratatatatatat of my

adrenalised heart, as I sit waiting for the 'enemy' to come and stone me in my fancy white-washed office with its white paged books and white shadows on the wall. The next moment lifting the lifeless brown limbs of the 'enemy' as he lies motionless on the sterile white sheets of a hospital bed, the life blown out of his spine by the bullet of an FN *rifle: a head without a body, breathing and thinking but not moving. Manhood can you be raised again? The enemy becomes the patient, becomes the friend, becomes the conscience.*

("Me" - 1980's)

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

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

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

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

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

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

What I am trying to convey in Postcard #4 is the unpredictability of working as an occupational therapist, the often unpreparedness of the therapist to deal with situations for which s/he is not necessarily trained. Our curriculum can never prepare us to deal with the complexity and multiplicity of situations, like the one described, which we will encounter during our working life, but it must provide us with a resilience and a *savoir faire* that makes it possible to know what to do when these situations arise. It is a type of inner therapeutic intuition and caring that is there in all of us but must be nurtured to extreme levels in those of us who work daily with individuals who have experienced intense physical and psychological trauma/illness.

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

Letter #2: Khulu's Story

Every Thursday morning during the academic term I join a multidisciplinary group of students at the Sthandokuhle first aid centre in the beautiful Ngcolosi district of the Valley of 1000 Hills. This fieldwork affords the students a service learning experience in a semi-rural setting, during which they work in partnership with the mothers or caregivers of children with disabilities, the children themselves and community health workers. Although it is tarred, the route to the first aid station is an extremely steep and treacherously winding road of approximately 6 kilometres. I travel in my own car and the students travel by mini bus taxi.

On several occasions during this trip I passed a most extraordinary sight: an obviously severely disabled man, pulling himself up this steep, winding and treacherous road by his hands while sitting

on a skateboard! The students also informed me that they had seen him before, begging in a shopping mall in the suburb of Pinetown, some 20 kilometres away.

Wanting to investigate further I phoned Sipho,, a community rehabilitation facilitator in this area, who set up an interview for me with the man in question. So one hot and humid, midsummer morning, when the African sun is close to its hottest, Sipho and I parked our vehicles halfway up the steep and treacherous tarred road and continued on foot down some 300 meters of very steep, winding and slippery gravel pathway. On the way we passed several homesteads, typical of the area, some traditional mud, wood and thatched rondavels, others a variety of Umjondolo type homes.[1] Each had its human residents who waved and greeted us as we passed, and the usual contingent of skinny, aggressive dogs, clucking hens and gregarious goats nibbling at the surrounding vegetation.

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

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

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

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

The cause of his impairments, he informed us, was witchcraft[2]. There was no illness or accident. He tells a rather confusing tale about a fight he had with some young boys and a bantam bakkie and that

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

it was after this that he became paralysed, implying that the boys had obtained the services of an uMthakathi. He was sent to hospital where he appears to have had some physiotherapy. Upon discharge he never saw his parents again and went to live with his brother and sister-in-law. She is a friendly and caring lady who joined us during the interview. She feeds him.

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

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

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

A Speculative analysis: What if?

There are several speculative questions that arise from Khulu's story which are relevant :

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

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

- Knowledge of, and respect for, specific aspects of the African lifestyle, value systems and cosmology are essential components in assessing needs and

bringing about meaningful rehabilitation to the many Khulu's we meet in our daily work.

Speculation 2: The question arises as to how possible it is to provide deep and insightful support to someone if one does not clearly understand or respect the individual's cosmology or world view. This does not mean one has to believe in that cosmology, but simply understand and respect its significance to those who believe in it.

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

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

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

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

Postcard #7: The Multiple Gaze

The medical model tends to reduce those it serves (patients) to a disease (the cerebro-vascular accident in bed 3), traumatic event (the motor vehicle accident in bed 5) or a body part (the fractured femur in bed 7). Almost everything about the individual is reduced to clinical components such as his temperature, blood count, amount and frequency of urinary and faecal eliminations, membranes, sputum and blood pressure. Essentially sterile, scientific and sanitary, it cures with medications, surgical procedures and regimens. It is disciplined, dictatorial and prescriptive where the doctor dictates and those who work under him follow his instructions. The 'patients' who are 'treated', succumb to the prodding, probing and prescriptive assessments and treatments accompanied by the multiple gazes brought upon them in ward rounds, the secret discussions in the duty room and the intimate details written about them in their files. They have to succumb to the indignities of exposure on the examination couch or in the operating theatre. during which time the patient is either horribly aware of the indignity imposed by the gaze and the often invasive procedures that accompany it or, as that needle slips into the vein, they are mercifully reduced to a blissful, anaesthetised state of amnesia from which they awake only to imagine shamefully what and who their body might have been exposed to while they were in this state of oblivion.

I recall in the late 1970's, when I worked in the intensive care unit with people who were comatose, I would frequently find deep blue and purple bruises around the soft skin on the anterior part of the upper arm at the axilla. This was where they had been pinched to assess their level of Consciousness through their reaction to pain on the Glasgow Coma Scale. And because the families of the victims kept asking what had caused the bruises, the pinching later moved to the back of the upper arm, to make the bruises invisible to the gaze of family members.

On another occasion I recall having to make a hand splint in the operating theatre for a lady who had been badly burnt and was undergoing a debridement under anaesthetic. She was fairly overweight and during the operation the surgeon remarked, "Shall I remove some of this adipose tissue while I'm at it?" at which most of us succumbed to laughter and giggling.

A ward round may be conducted by three or four doctors and interns, a handful of nurses and often the physiotherapist, occupational therapist, speech and language therapist and social worker i.e. give or take, anything from 8 to 15 people at a time. Typically this "team" with their white coats, stethoscopes and note books move from bed to bed, and at each bed arrange themselves in a semi-circle around the 'patient' so that s/he is literally surrounded by their gaze. Then each team member relates back to the doctor what progress or not, s/he has made during the week. The doctor may at any time request that the 'treatment' or an aspect of it be changed. Rarely, if ever, is the 'patient' requested to comment on their own experience of their 'treatment' and even if they were asked to do so it is highly unlikely they would complain about any aspect of their 'treatment' under such a multiple and intimidating gaze.

The description in this postcard is a collage of my own experiences both as a 'patient' and as an occupational therapist within the intensive care, ward round and operating

theatre situation. They deliberately relate several negative incidents and do not relate the frequent positive incidents that may occur daily within the hospital and ward setting. The intention is not to undermine the beneficial work that medical doctors and other health care workers do in alleviating pain, illness and suffering under the umbrella of the medical model, but to show how, sometimes in its very correctness, it can be so incorrect and how, in its preoccupation with controlling, it loses sensitivity for the humanity of the very people it is supposed to serve.

Michel Foucault (Fillingham, 1993) uses Bentham's panoptic schema[3] to illustrate the spatial partitioning that occurs within the institutional setting as a means of control and surveillance[4]. This spatialization and gaze is everywhere we care to look in the medical setting: it can be seen in the glassed-off nurses' station or 'duty room' which overlooks the ward and from which surveillance can occur, in the two-way mirror in various therapy settings from which we observe the 'patient' while s/he is busy with an activity and where s/he is unaware of our gaze. Ironically, in the ward round, as described in the narrative above, there is a modification of this panoptic concept, it is turned inside out: instead of one medical practitioner surveying a group of 'patients' from a single vantage point, the situation is reversed and a single patient becomes the object of surveillance of a large group of practitioners. In addition the spatial partitioning of the object of observation and the observers is such that, instead of the person observed being on the outside of the central, fixed position of the gaze, they are literally surrounded by it – there are eyes everywhere - and the gaze is not directed from a level equal to theirs but trained down upon their prostrate and vulnerable bodies from an elevated and controlling position. It is difficult to argue that such a situation is not intimidating.

And so now having shared these intimate and provocative glimpses with you it is time to conclude and I am going to do this by sharing a poem with you which I have written specifically for this presentation. It is about the people that form such an important part of many of our daily lives creating so many emotions and is simply titled:

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[3] A panopticon is the central tower in a prison from which the guard has a clear view of all the prisoners situated in an illuminated circle around his tower, but the prisoners could not see each other or the guard. Bentham envisioned such a system for hospitals, schools, factories and barracks. [In:Fillinghamm, L.A. (1993). **Foucault for beginners**. Writers and Readers Publishing Inc. New York.]

"Students"……..

As you have moved through my life from year to year

Coming and going, A growing, grumbling, giggling group,

Smelling of sun ripe youth and sweat, brown-skinned, blond-skinned, I gaze in awe as you go

Daughters and sons of mothers, sisters of brothers, brothers of sisters, children of fathers

The Sons and daughters of my barren womb.

Becoming lovers and mothers

Becoming purposeful, professional people

Going out to be and become, to change and be changed

to laugh, cry and even to die

To turn around lives that are slipping into crevices of pain and misery

To pull them back from the brink,

Back from the sink into desperation

To give them back purpose and poise

To dig their dignity out of the dank soil of distress and help them become again

As you have moved through my life

Living stream of student flow

Sly,shy,sad,mad,laughing and loud

I watch in awe as you go

And am so sweetly, meekly, deeply proud

Stop awhile and come and smile with me!

Thank you for the privilege and honour of being invited to present at this very special occasion.

REFERENCES

Joubert, R.W.E. (2007) Indigenous fruits from exotic roots? Revisiting the South African occupational therapy curriculum. Doctoral thesis, University of KwaZulu-Natal, Durban.

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

Fillinghamm, L.A. (1993). **Foucault for beginners**. Writers and Readers Publishing Inc. New York.

Ngubane, H. (1977). **Body and mind in Zulu medicine: An ethnography of health and disease in Nyuswa-Zulu thought and practice**. Academic Press. London.