

**I'M GOING BACK TO WORK: PERCEPTIONS AND EXPERIENCES OF
BACK REHABILITATED CLIENTS REGARDING THEIR WORKER ROLES**

**A DISSERTATION SUBMITTED IN FULFILLMENT OF THE
DEGREE M.SC.OCCUPATIONAL THERAPY**


**Department of Occupational Therapy
University of the Western Cape**

SHAHEED SOEKER

Student number: *****

October 2004

Supervisors: Lisa Wegner

Blanche Pretorius

The sharing of knowledge is important.

However making use of that shared knowledge is even greater.

Shaheed



DECLARATION

I, SHAHEED SOEKER, hereby declare that the work on which this thesis: *I'm going back to work: Perceptions and experiences of back rehabilitated clients regarding their worker roles*, is my own original work (except where acknowledgements indicate otherwise), and that neither the whole work nor any part of it has been, or is to be submitted for another degree in this or any other university.

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Acknowledgements

Participants

To all of you who participated in the research process, I would like to thank you for your enthusiasm, dedication and commitment. Without your participation this research would not have been possible.

Lisa Wegner, (supervisor)

A committed supervisor, who remained an excellent guide, as well as friend throughout this journey that I have undertaken. I am thankful for your kindness and patience, particularly when putting the brakes on me when I got carried away with my ideas.

Blanche Pretorius (co-supervisor)

Thank you for your dedication and faithfulness to my ideas throughout the process especially when my thought processes were clouded. Your time and patience will not be forgotten.

Cannon Collins Educational Trust for South Africa

Thank you for your financial support throughout the study. May the Educational Trust continue with its good support to students for many years to come.

The Tygerberg Hospital Occupational Therapy Department

Thank you for your support on all levels particularly financial and for the use of your facilities. Special thanks to Farhana Karachi, Carmen Karsten, Leonie Esterhuizen, Anne-Marie du Plessis, Abdul Hadee Vent and Hendrik Volschenk.

Rehabsa (Rehabilitation Centre)

Particularly, Lindsay Scott and Carl Warlberer for providing some of the clients that participated in the study.

University of the Western Cape

With your financial support many obstacles were eliminated during the completion of the study.

My **family** who have supported me throughout my endeavour:

Thank you for your patience and assistance especially during periods of difficulty.

Definition of terms

Low Back Pain: this describes an “anatomic location of discomfort and is not technically an acceptable medical diagnosis” (Tollison & Kriegel, 1989:ix). The term is used within the study to identify the location of participants` pain that disables them from participating within their worker roles.

Health Promotion: this describes “a shared practice view of priorities for improving health of the practice population. This may involve a strategy of networking and skill utilisation between primary care and community health services, local authorities and the voluntary sector” (Doyle & Thomas, 1996:3).

Occupational Therapy: is defined as an art and a science that is aimed at improving functional independence of clients or patients through the therapeutic use of purposeful occupational activities in a holistic manner (Schwartz, 2003).

Focus Groups: an open group discussion between specifically selected persons with the purpose of collecting research data under the leadership of a group leader who is trained and experienced in handling group dynamics (de Vos et al, 1998).

Client-Centred Approach: a practice modality that involves the client as the primary decision-maker especially in the establishment of therapeutic goals. The client must be actively involved in all phases of rehabilitation and must understand what the assessment involves. The client is directly involved in drawing up his/her own treatment aims, based on the problems he/she has agreed to work on (Sumsion, 1993).

Return to Work: for the purpose of this study the term refers to the period of participation in vocational tasks after the client has completed or experienced interventions such as surgical treatment, physiotherapy and occupational therapy. The time period before the back injured individual participates in work related tasks usually ranges from twelve weeks to two years (Press cited in Napoli, 2002).

Facilitators: the term refers to those factors that are seen as facilitating or contributing towards the return to work process. The World Health Organisation (WHO) also defines these as “factors in a person’s environment that, through their absence or presence, improve functioning and reduce disability. These include aspects such as the physical environment that is accessible, the availability of relevant assistive technology, and positive attitudes of people towards disability, as well as services, systems and policies that aim to increase the involvement of all people with a health condition in all areas of life. Absence of a factor can also be facilitating (e.g. that absence of stigma or negative attitudes). Facilitators can prevent an impairment or activity limitation from becoming a participation restriction, since the actual performance of an action is enhanced, despite the person’s problem with capacity” (W.H.O, 2001:192).

Barriers: the term refers to those factors that prevent or negatively influence participation in the return to work process. The World Health Organisation also defines these as “factors in a person’s environment that, through their absence or presence, limit functioning and create disability. These include aspects such as a physical environment that is inaccessible, lack of relevant assistive technology, and negative attitudes of people towards disability, as well as services, systems and policies that are either non-existent or that hinder the involvement of all people with a health condition in all areas of life” (W.H.O, 2001:192).

Adaptations: this term refers to “an active response to a challenge in the environment that is self-reinforcing and that becomes most effective when it is organised subcortically as an unreflected habit” (Frank, 1996:47). It also refers to any adjustment or changes in response to new expectations or demands in order to make tasks simpler or less demanding to promote greater success (Crepeau et al, 2003).

Model of Human Occupation: this model seeks to explain the occupational functioning of individuals. It focuses on how people choose, order and perform occupations as part of their everyday lives. Occupations include productive or school-related tasks, activities of daily living or self-care tasks, and leisure or play tasks (Kielhofner, 1992)

Perceptions: the meaning the brain gives to sensory input. It is a subjective experience that is above and beyond the mere recognition of sensory data (Ayres, 1972). It is also defined as the mental process involving recognizing and meaningfully interpreting sensory information (Crepeau et al, 2003).

Experience: the direct participation in an activity over time (Crepeau et al, 2003). It is also defined as the process of gaining knowledge and skill through doing and seeing (Hornby & Ruse, 1988).



Abstract

Clinical research has shown that patients experience difficulty in adjusting to their pre-morbid worker roles after they have been through a back rehabilitation programme. The pressure and competitiveness of modern day society to achieve competence and to survive has proven to be stressful, both for the injured and uninjured, the unemployed and employed. Back rehabilitation and the successful return of the injured worker to the workplace have been of great interest to industry for the last decade, due to the ever-increasing support of legislature for the injured. There is a range of medical interventions available but few of these achieve successful outcomes due in part to the fact that many intervention strategies do not take the patients' perspectives into consideration. Therefore, the purpose of the study was to explore back-rehabilitated clients' perceptions and experiences of the challenges they face in adapting to their worker roles.

Qualitative research methodology was utilised in order to explore the research question. Participants were selected by means of random sampling from the Tygerberg Hospital Occupational Therapy Department and Rehabsa Rehabilitation Clinic. Semi-structured focus groups consisting of broad questions followed by probing were used to elicit rich descriptions about the participants' experiences and perceptions. One pilot testing group and six, two hour focus groups were conducted and consisted of an average of four participants per group. The data that was generated was qualitatively analysed using a manual coding system to obtain codes, categories and themes.

The study was aimed at eliciting individuals' perceptions and experiences of facilitators, barriers and adaptation processes that affected their ability to resume their worker role. Factors that were seen as facilitatory included improved communication and transparency between stakeholders, injury management strategies and empathy amongst stakeholders that facilitated teamwork. Factors that prevented individuals from resuming their worker roles were regarded as barriers. These included delays and inefficiency of all types such as poor management procedures, poor quality medical interventions, poor workplace accommodation procedures and unsupportive environmental systems. In order to

put these barriers and facilitators into perspective, Kielhofner's Model of Human Occupation was used as a framework for understanding the factors that impacted on the participants experience for returning to work. The adaptive processes that individuals participated in were explained through the application of an "Adapted Atomic Model of Balance". Therapists working in the field of back rehabilitation will be able to apply this model in order to ease the transitional role from patient to worker.

Recommendations included improving the insight of stakeholders with regard to early, effective on-the-job training, initiation of health promotion through education within the workplace as well as in the community, and developing flexible work and medical policies. Broad principles of practice that guide occupational therapy back rehabilitation are explored. Points for future study within the area of occupational science and occupational therapy are identified.

Keywords: low back pain, health promotion, occupational therapy, client-centred approach, return to work, facilitators, barriers, adaptation, focus groups, Model of Human Occupation.



1. Chapter One: Introduction

1.1 Background

Due to the increase in people taking sick leave as a result of back pain, the problem of chronic back related pain disorders is a major topic of discussion in South African healthcare and social security services. The Western Cape has a population of 27 984 000 of whom 11 029 000 belong to the working population (South African Department of Labour, 2002). The high rate of unemployment acts as a precursor for the potential influence of poverty on the population. This has a significant impact on the back injured population especially those within industrialised occupations (Kisting, 1996). Workers injured while doing unskilled work for minimal wages often become unemployed with no other source or means of income, thus reinforcing poverty in their lives. According to the Department of Labour, for the years 1996 and 1997 an amount of R144 747 808.20 was paid to back injury claimants because of their incapacity to work. This incapacity could be attributed partly to the complicated nature of, and treatment for, back pain (Guzman et al, 2001).



In general, low back pain* has a short duration and during the pain period about 80% of people are able to continue to work (Reneman et al, 2001). Of those people who stop working, 5-10% are still unable to work after three months due to ongoing low back pain (ibid, 2001). The back pain is regarded as chronic if the pain duration is for a period of 3 months or longer.

In about 90-95% of these cases, the nature of these complaints is non-specific, thus making therapy difficult. Besides the tendency of low back pain to persist, there is also a tendency for the individual to relapse after final recovery (ibid, 2001). In many countries low back pain is a common cause of long term disability in middle age. Chronic low back pain is resistant to treatment and patients are often referred to multidisciplinary treatment facilities. In these facilities health professionals from various disciplines are involved with the assessment and treatment of back injured individuals. This results in the utilisation of many different approaches to treatment depending on the professionals' philosophy and interpretation of the back injured individual's problem.

*For purposes of the study the terms low back pain and back pain will be used interchangeably.

One approach that is applied by treatment facilities is the biopsychosocial approach. This approach is commonly utilised in the rehabilitation of back injured individuals who has symptoms of chronic pain that develops as a result of multiple interrelating physical, psychological, social and occupational factors (Guzman et al, 2001). Chronic pain symptoms have tormented back pain sufferers and plagued treatment approaches for many years due to the multifaceted nature of the back condition (ibid, 2001). It is therefore not surprising that a 100% success rate is seldom achieved in rehabilitation settings. At a local multidisciplinary back rehabilitation centre in Cape Town, of a total of 58 clients who had been rehabilitated during the preceding 17 months, 74.2% returned to their previous work, 5.2% participated in insurance rehabilitation, 10.3% were not working, 1.7% were working in alternate positions at the same work, 3.4% required further medical intervention and 5.2% were negotiating alternative employment (Rehabsa, 2002). Although these statistics reflect only a small portion of the back injured population, it indicates the complicated nature of back injuries and the difficulty in the treatment thereof. This problem is compounded by the fact that individuals who receive treatment at centres like Rehabsa are a select few of whom are either cash paying clients, individuals that are receiving financial benefits from Workman's Compensation, or are being funded by medical aid schemes. This raises questions about the quality of treatment that the unemployed or poverty-stricken back injured population receives and the consequent incapacity statistics that result. These individuals are forced to attend community day hospitals where there are limited rehabilitation assistance offered due to few occupational therapists being employed and where physiotherapy services are over-subscribed. The community day hospitals are often overcrowded and have poorly equipped consultation rooms as a result of health budget constraints. Physicians end up treating these individuals with the most cost-effective methods available such as pain medication and bed rest. This often results in an inaccurate diagnoses and poor treatment of the back injured individual's condition, which eventually becomes chronic, thus severely hampering their functional abilities (Watts, 1989).

Inequality amongst service providers also has a huge impact on back injury intervention strategies. According to a recent survey initiated by the Department

of Health (Case disability survey for the Department of Health, 1999), Whites¹ and Indians were the most likely race groups to receive medical rehabilitative services. In the Western Cape there is only one private work rehabilitation centre, which is located in the Parow area within the Northern Suburbs (to date). The northern suburbs were traditionally inhabited by individuals from the predominantly white race of whom many were from an affluent background. This therefore resulted in only privileged individuals being able to access the services of this back rehabilitation clinic. This could also be seen as a measure of reflecting the unequal provision of services such as back rehabilitation clinics amongst the different race groups within the Western Cape.

Although everybody has access to this limited service, there is the issue of cost², that causes the unemployed, who do not qualify for Workman's Compensation and who may not have private insurance or medical aid, to be denied the quality of intervention that is required after a back injury. Back injuries do not only have a negative impact on the individual but also have a crippling impact on the economy, particularly the labour and industrial sectors of the country. According to the South African Bureau of Labour Statistics, approximately one million work related injuries, illnesses and muscular sprains, 20% of which were to the back, resulted in lost workdays (Greenberg & Bello, 1996). Injured employees are often financially compensated according to the Compensation of Injuries and Diseases Act (COIDA) of 1993 based on their level of income and if the injury occurred while they were on duty (Kisting, 1996). This indicates that lower waged employees who receive minimal benefits would not be able to acquire specialised medical intervention due to high medical costs.

¹ For purposes of the study the terms (white, caucasian, black and coloured) will be used as descriptive indicators of the different populations within this study. The researcher does not intend to offend anybody as these terms are only used for purposes of the study.

² According to Rehabsa Clinic, an individual who had experienced a back injury would have to pay R6523.80 if they were compensated by a medical aid scheme and R5708.70 if they were compensated by the Workman's Commissioner to participate in a back rehabilitation programme.

1.2 Rationale

The Labour Relations Act (1995) supports equal opportunities for the disabled or chronically ill within the workplace. However, many disabled individuals experience difficulty in finding or maintaining their employment. Similarly, the National Rehabilitation Policy emphasizes that consumers of health care be involved in designing, implementing and monitoring community based health services. However, there is minimal research that has investigated the policy in practice (Rehabilitation Services, 2004).

Clients' perspectives and experiences of their worker role in the return to work process are seen as imperative for the development of good quality treatment interventions and successful outcomes of rehabilitation (Friesen et al, 2001). These perceptions and experiences could be used as a measure of investigating, developing, implementing and evaluating intervention strategies that could facilitate early sustainable return of the injured worker to the workplace.

In the declaration of the Ottawa Charter of 1986, the World Health Organisation established cost-effective rehabilitation initiatives such as Health Promotion in an attempt to eliminate poverty and prevent chronic diseases (WHO, 1986). The aim of Health Promotion is to empower communities with skills and resources to eradicate preventable diseases and illnesses. Health Promotion is described in the Ottawa Charter as the process of enabling people to develop services, increase control over and improve their health (ibid, 1986). Within South Africa, the consumers of health services have had little influence on the planning and monitoring of rehabilitation services (Philpott & McLaren, 1997). It can therefore be argued that the latter contributed to the back injured individuals' inability to value these rehabilitation facilities or inability in determining whether these facilities meet their needs.

Rehabilitation services have previously been randomly implemented and in isolation from one another. Much of the evaluation and monitoring of treatment programmes has been based on the medical model with the health professionals being the experts and often ignoring the patient or consumers needs (ibid, 1997). These treatment programmes lacked the objectivity of the consumers (e.g. back

injured clients) who could be involved in improving, planning, organising and implementing intervention programmes. This is where health promotion, as a strategy for injury prevention as well as programme development to a greater extent, can be explored. A decision was therefore made by the researcher to approach the problem regarding the inefficacies in treatment interventions from a health promotion approach.

1.3 Personal encounters as an occupational therapist

My experience with the Health System has brought me to the realisation that individuals suffering from low back pain have been stigmatised and victimised by individuals (e.g. family members, medical professionals, employers) who tend to not believe that they have a legitimate problem. According to research literature (Smithline & Dunlop, 2001), the older generation from the age of 45 years is more susceptible to low back injuries than the young. However, from my own professional perspectives and experiences as an occupational therapy practitioner, at the Tygerberg Hospital Work Assessment Unit, this is not always so. I have assessed clients with low back pain from as young as 25 years old who had undergone rehabilitation for their low back injuries and had limited success in returning to work. This caused me to believe that back injured individuals were not always receiving the most appropriate treatment or that the treatment alone was not sufficient to minimise lower back injuries.

Moreover, I have seen individuals that accept the current health system and its inadequacies in terms of care and treatment. A typical back injured individual that experiences chronic back pain would be treated conservatively with analgesic medication and bed rest, thereafter the individual becomes entangled in the political, economic and social stereotypes of the condition.

One particular role that allows us to form a society is our interaction and co-operation with each other in our worker roles. Due to apartheid and its unequal distribution of employment opportunities, poverty amongst non-white communities escalated. This caused me to believe that many poor back injured individuals lack access to private back rehabilitation programmes due to the expensive nature thereof. It could therefore be argued that mainly the rich back

injured individual received the quantity and quality of care that is needed to treat the back injury. Furthermore, current treatment approaches tend to lack holistic intervention i.e. assessment of an individual by an inter/multidisciplinary team and therefore, reinforcing poor communication amongst service providers, duplication of services and limiting goal orientated treatment.

It is because of these questionable circumstances and the multifaceted nature of the back injured individual's condition that I have decided to explore the topic in greater detail. Therefore, research on the return to work process will be conducted from the perspectives and experiences of back injured individuals.

1.4 Conclusion

This chapter reviewed the significance of the study for the exploration of the perceptions and experiences of back injured individuals with regard to their worker roles. These concepts will be explored in further chapters by means of interpreting the barriers, facilitators and adaptation processes that challenge the injured worker in the return to work process. Therefore, this study will develop recommendations for a more appropriate return to work model in order to facilitate the re-entry of people with back injuries into the work force. This will be accomplished by investigating the factors that influence the ability of back injured individuals to resume their worker role after back rehabilitation.

Outline of chapters

Chapter One

Chapter One comprises the background of the study, rationale, context and outline of the study. The researcher also discusses his personal encounters as a therapist, which served as a motivator to pursue the current study.

Chapter Two

Chapter Two will be dedicated to the literature review where the researcher will emphasise the key concepts around which the study is designed and therefore demarcate the study from the body of knowledge concerning back rehabilitation.

Chapter Three

The methodological principles of the study design are presented in this chapter. Concepts such as study design, participant selection techniques, number of participants, data collection methods and analysis processes are clarified.

Chapter Four

The results of the study are described within this chapter. Patterns, trends and relationships that emerged from the data analysis are clarified and presented as themes.

Chapter Five

This chapter will be dedicated to the in depth analysis and discussion of the results of the study whereby interpretation will be facilitated by means of two models that relates themes to theory.

Chapter Six

This chapter deals with the conclusions that were reached after the analysis and discussion chapters. Thereafter recommendations for future research and programme development are made.



2. Chapter Two: Literature Review

Contextualising the study

2.1 Overview

The literature review was undertaken in order to:

- Provide a required foundation for understanding the concept of pain by defining pain, providing a historical view of pain, and unravelling scientific/cultural beliefs about pain. This would then contextualise pain as a precursor to discussing low back pain.
- Provide a pragmatic view of low back pain, by focussing on the evolutionary anatomical development of human beings as a mechanical stressor that contributes to low back pain in individuals.
- Explore possible explanations for the development of acute to chronic back pain and investigate the efficacy of past and current treatment approaches. This would highlight the challenges that health professionals face in choosing an appropriate medical intervention in remediating the myriad of symptoms of the back pain sufferer.
- Describe occupational therapy as a choice of intervention with specific reference to client-centred care as the underlying philosophy. Thereafter, the Model of Human Occupation is used to explore human occupation as a precursor to health and worker role performance.
- Describe the occupational performance area of work as a social, productive and developmental activity that is dependent on environmental feedback. This would highlight the psychological and physical risk factors that result in occupational dysfunction within a work environment. In addition, adaptation as a process within an individual's lifespan is discussed with the view of overcoming environmental stress.
- Explore the potential of health promotion through creating awareness, education and fitness programmes within the context of back rehabilitation. This would provide a new approach in which to view the low back pain phenomenon.

2.2 Pain

2.2.1 Historical view of pain

The International Association for the Study of Pain (I.A.S.P) defines pain as an unpleasant sensory and emotional experience associated with actual or associated tissue damage (I.A.S.P., 1986). Tollison and Kriegel (1989) viewed pain as having many sources. Either it originated from within the body or its origin was regarded as external. The external causes of pain were often seen as being caused by evil forces, punishment from the gods or spiritual magical entities in early civilisations. Bodily disturbances were viewed as diseases and mind disturbances were related to spiritual-magical or theological issues. This resulted in two explanations for pain (viz. organic pain and inorganic pain groupings).

In recent times advancement in the field of medical science, identified biomedical (organic) and psychophysiologic (inorganic) causes of pain (Smithline & Dunlop, 2001). This was evident in the application of psychiatric diagnosis (conversion hysteria, psychogenic pain and compensation neurosis) as an explanation for all pain disorders without clear, objective clinical findings. New discoveries in medicine identified the role of important neurotransmitters (e.g. serotonin, norepinephrine and endorphins) in pain reinforcement or reduction and the role that emotions play in sustaining “sick role behaviour” (ibid, 1989). This therefore countered the assumption that a simple sensation en route to a pain center in the brain was the cause for pain and recognised that cognitive factors could have a direct effect on the experience of pain.

2.2.2 Low back pain

Industrialization has led to an increase in back injuries particularly in industries that require the repetitive lifting of heavy objects (Jones & Kumar, 2002). Back disorders have been cited as the most expensive health care problem in the 30-50 year age group and the leading cause of disability in adults below 45 years of age (Kelsey cited in Jones and Kumar, 2002).

According to Roozee (1990) low back pain (L.B.P) has plagued human beings since they were able to stand upright. The evolutionary placement predicament of human beings going from quadruped to biped, with the back taking abuse, may be

one of the causes for the prevalence of L.B.P. This is evident in that the lumbar spine of a human is susceptible to strong kinetic forces. These forces result in the individual becoming vulnerable to trauma and injury.

The time period in which an individual's back pain develops into a chronic state is controversial. L.B.P that lasts for less than three months could be termed acute as an individual could recover without medical intervention (Drezner & Herring, 2001). However, Finneson (1980) differs, stating that an individual's pain can be termed as chronic if it persists for more than three days. Alternatively, the development of chronic pain could be related to fear of reinjury, overly protective spouses and sick role familiarity (Joy et al, 2000). It could therefore be argued that these reinforcing factors result in a poor return to work rate particularly when the individual is being financially compensated for his/her losses.

Medical training commonly teaches that 60% of patients with L.B.P will recover spontaneously within 6 to 12 weeks without medical intervention. Given this favourable course, some physicians question whether acute L.B.P requires any specific treatment such as medical, surgical and physiotherapy. Longitudinal studies by Von Korff and Saunders (1994) suggest that back pain is typically recurrent and that chronic back pain occurs more frequently than previously believed. Therefore, the long-term outcome in patients with L.B.P. is less favourable than once perceived (Herring, 2001). This indicates that spinal function may be restored even though pain continues. However to the contrary, the absence of pain symptoms does not necessarily indicate the restoration of normal physical functioning. The development of chronic pain symptoms in non-specific disorders could therefore be considered as the result of an abnormal course of acute pain for which physical, psychological, social and economical factors are responsible.

2.3 Approaches in treatment

The biomedical approach is commonly used to investigate the client's physical capacity in terms of cardiovascular endurance, muscle strength and range of motion. The traditional approach of surgical intervention or conservative care

characterised primarily by bed-rest, muscle relaxant medications and passive physiotherapy could be seen as examples of this approach. The medical profession has historically utilised the biomedical approach with solo practitioners providing direct services to patients on an individual basis. According to Tollison and Kriegel (1989) a common problem with this approach is that although this model may be appropriate for the majority of acute diseases, chronic disorders such as intractable back pain has led to the need for a comprehensive approach to treatment. As most physical performance tests are determined by psychological factors, such as cognitive, emotional and motivational components, a cognitive behavioural programme was developed. This programme focussed on client education, regarding issues such as improving their insight into their condition, coping with pain and avoidance behaviour (Reneman et al, 2001).

Chronic back pain with its complex medical, psychological and social problems has led medical researchers to identify the need for a comprehensive team approach in treatment (Tollison & Kriegel, 1989). This comprehensive team favoured a biopsychosocial approach in the rehabilitation of the back injured individual. Therefore acknowledging the role of non-surgical interventions such as behaviour management, group therapy and family therapy in controlling pain symptoms (ibid, 1989).

It is evident that work fitness is a problem for back injured individuals in their attempt to bridge the gap between medical rehabilitation and the workplace. This has led to the development of work hardening programmes, back schools and work capacity evaluations (Smithline & Dunlop, 2001). These work orientated programmes are seen as an integral part of the biopsychosocial approach and is regarded as essential in controlling back pain symptoms and improving the back injured individual's employability status (Kornblau, 1989).

The biopsychosocial treatment approach aims to restore the functional abilities and the reintegration of the individual into society. This approach acknowledges the importance of holistic treatment. However, current treatment modalities tend not to fully acknowledge client individuality in developing programmes. This in turn, highlights the need for a client-centred approach in therapy, which allows

the client to take responsibility for his/her rehabilitation. According to Bergstrom et al (2001), matching of treatment to the patient's needs (client-centredness) may enhance treatment outcome, reduce pain and suffering among chronic spinal-pain patients and facilitate a better health economic distribution of treatment resources. The biopsychosocial approach facilitates the return to work process by encouraging the injured worker to resume modified duties within their previous occupation. This would then serve as a method of functional rehabilitation.

According to Krause et al (1998), injured workers who were offered modified work had twice the rate of return to work as those who were not. There is substantial evidence indicating that employers who promptly offer modified duties can reduce time lost per episode of back pain by at least 30%, with frequent spin-off effects on back pain claims as well.

Overall, theoretical approaches to the treatment of the back injured individual do not indicate a significant success rate. This therefore emphasises the difficulty experienced by medical professionals and patients in developing an adequate rehabilitation programme.



According to Friesen et al (2001), worker attitudes and motivation for participation must be acknowledged and addressed if more injured workers are to be successful in returning to fulltime employment. Therefore, theories based on the client's motivation were seen as being of value when exploring the return to work process. Cognitive theories of motivation have been suggested as appropriate constructs for understanding individual differences in motivation in returning to work behaviour following work injury (Roessler, 1989). This indicates that the worker's subjective view of self in terms of becoming re-injured within the work environment plays an instrumental role in the return to work process. Studies have shown that money in the form of Workman's Compensation or litigation could also be a motivator for pain behaviour (Reneman, 2001). This indicates that the pain experienced by some back injured individuals is rewarding in itself because of the financial rewards, sympathy, attention and concern it generates in favour of these individuals. According to Hildebrandt (1998), the effectiveness of current treatment approaches has not been proven significantly

and this is evident in the annual increase of individuals with chronic back pain. It can be deduced that previous back pain research has concentrated efforts on treatment from a health professional's point of view, failing to thoroughly acknowledge the consumer or back injured individuals' perspectives or opinions when planning intervention strategies.

2.4 Occupational therapy

2.4.1 Occupational therapy practice

Occupational therapy is a discipline that is aimed at improving functional independence of clients through the therapeutic use of purposeful occupations and activities in a holistic manner. Occupational therapists traditionally serve individuals who have been displaced from work through disability (Spencer et al, 1998). Occupational therapy is based on client-centred care that involves the client as the primary decision maker in the treatment process. As noted previously, the patient with chronic low back pain has physical, psychological, social and economic limitations. The occupational therapist has the skills to assess the possible physical and psychological complications that might result from a back injury. Physical limitations that might hinder the individual's physical performance include joint range of movement restrictions, muscle weakness and nerve impairment. It is seldom that the treating therapist can separate the physical complications from the psychological effects of the injury. This is where the therapist will actively rely on his/her skills by treating the back injured individuals' symptoms of depression, anxiety and fear of returning to work with carefully designed activity programmes. These programmes can consist of anxiety management and back education programmes to work hardening/work abilities retraining programmes (Roozee, 1990).

Therefore, with these skills the occupational therapist is a vital and important member of the health care team in the treatment of back pain (Roozee, 1990). Therapists guide treatment techniques and intervention strategies by means of therapeutic models. Therapeutic models designed from the occupational behaviour perspective are commonly used to explain the daily routine of work within a physical temporal and social environment (Matsutsuyu, 1971). Popular models used within the context of the occupational behaviour perspective are the

Model of Human Occupation (M.O.H.O), the Ecology of Human Performance Model (E.H.P.M) and the Person Environment Occupation Model (P.E.O.M). M.O.H.O is viewed as a clinical model that has more than eighty studies completed and published whereas the E.H.P.M and the P.E.O.M are viewed as conceptual models with limited application in practice (Kielhofner et al, 2003; Dun et al, 2003; Stewart et al, 2003). Therefore, for the purpose of this study the M.O.H.O will be used to provide insight into the client's functional status.

2.4.2 Model of Human Occupation

The Model of Human Occupation was developed to explain how individuals perform everyday occupational behaviour. It concentrates on both the individual's characteristics and the environment as factors that influence choices and behaviour (Kielhofner, 1992). The model consists of three components namely:

1. The viewing of an individual as an open system.
2. The identification of three subsystems that regulate choice, lifestyle and performance.
3. The acknowledgement of the nature of the environment and its influence on the person.



The Model of Human Occupation can be regarded as the most suitable model for conceptualising a frame of reference to describe the relationships of the various factors that impact on the injured worker. According to Kielhofner (1995) the Model of Human Occupation aims to explore the value that occupation has on an individual's biological, psychological, social and cultural development.

2.5 Human Occupation

An individual's level of health is dependent on the adaptive qualities of the individual's occupation (Yerxa, 1983). This indicates that participation in occupations is essential to the client's biological, psychological and social well-being. An occupation can positively influence the biological functions of individuals such as musculoskeletal and cardiorespiratory functioning. Sensory deprivation experiments reveal that if the brain does not receive the influx of information through interaction with the world then neurological disorganization occurs (Kielhofner, 1992). Psychologically, individuals are attracted to an

occupation through intrinsically motivated properties of engagement in occupation such as self-affirmation and self-confidence. Occupations have their own rewards, such as extrinsic rewards (e.g. monetary, status). However, they are not the primary motives for choosing occupations. Rather, the occupational motive emerges out of biologically and culturally based desires to engage in activity and to realise a degree of mastery (Kielhofner, 1992).

Individuals are occupational beings who define themselves by occupations that are meaningful and purposeful (Barret & Kielhofner, 1998). These occupations can further be subdivided into occupational performance areas such as activities of daily living, work and leisure pursuits. Work tends to be the most dominant performance area within the lives of adults due to the amount of time spent weekly in the workplace (Barrett, 1998).

2.6 Work

The Model of Human Occupation describes work as activities where remuneration is optional and where a service or commodity is provided to others (Kielhofner, 1995).



Work, as an occupation, plays an important role in the maintenance of society and culture. This is where the distinctions are made in society for the divisions of labour and the integration of individuals into specialized work units. Members of society rely on the productivity of others to generate resources that they require. This productivity is exchanged among members in formal and informal ways. Work forms the basis for the development of products such as utilitarian or artistic objects, ideas, knowledge, assistance, information sharing and protection. It therefore enables the individual to improve his/her ability to be productive (e.g. studying) and inevitably to develop his/her worker role (Kielhofner, 1992).

According to Guevara and Ord (1996) individuals develop meaning from specific aspects of the work context, for instance work practices, organisational structures and cultures, rules and procedures, management style, pay and rewards. Work plays an integral part in the development of an individual's self-esteem and fulfils numerous individual needs. These include the needs for economic security,

socialisation, status, creativity and self-expression. An individual's self-esteem within the workplace can be negatively or positively affected when factors in the workplace impact on his/her worker role. Sometimes the psychosocial factors within the work environment may not only contribute to the causation or aggravation of a disease but also affect the curative or rehabilitative measures of the disease (Kalimo, 1987). The psychosocial components of workplaces have been found to have a greater impact on the back injured individual's return to work rate than the more physical requirements of the job. Psychosocial risk factors that negatively affect the return to work rates of the back injured include factors such as high time pressure, monotonous or boring work tasks, low job satisfaction, low social support and uncertainty of how to perform work tasks (Linton, 1990).

Physical risk factors that could exacerbate the complexity of the problem include uncomfortable work postures such as repetitive arm movements, heavy work, vibration, too much or too little sitting and lack of breaks (Hoogendoorn et al, 1999). These factors can seriously affect the individual's occupational performance of work that might result in occupational dysfunction. Occupational dysfunction arises when the demands of the physical environment exceed the individual's functional capacity in executing tasks. Occupational dysfunction occurs when there is an imbalance between multivariate factors including biological, psychological and ecological stressors. This could result in individuals not contributing to society and an increased burden and cost to society to support these dysfunctional members (Kielhofner, 1992). Occupational dysfunction is quite evident amongst the back injured population whereby incongruence is seen in the individual's innate abilities such as the individual's physical and cognitive capacity as well as the demands of the work environment.

According to Lu (1999) physical and mental capacities influence each other but are in turn influenced by the environment. In an ideal situation the individual's functional capacity is in balance with the total demands of the environment. In a case where disequilibrium is interpreted as dysfunction, complaints such as low back pain will continue until balance has been re-established. This balance is

dependent on the individual's manner of adapting within a stressful environment (Kielhofner, 1992).

Adaptation within the lifespan of a human being is crucial to the development of skill and mastery over tasks. According to Schultz and Schkade (2003) occupational adaptation is described as an internal adaptation process that occurs through occupation and for occupation. They viewed competency in occupation as a life long process of adapting to the demands of the person, occupation and the environment. Somerhoff (1969) describes adaptation as having three time spans (i.e. long term, medium term and short term). This corresponds to evolution, ontogenesis and immediate learning. Evolution can be related to the survival value of man's symbolic capacity to deal with a variable environment through learning. Ontogenesis is the middle time span of adaptation and refers to the organization of learning that occurs during the individual's lifespan as a result of experiences from environmental interaction. Immediate learning is the shortest time span of adaptation i.e. learning that occurs in the present that results in a balance between the actions of the organism and the demands of the environment (ibid, 1969). Adaptation within the context of the back injured, could therefore be interpreted as a state of equilibrium between the individual's functional capacity as well as physical, mental and environmental factors or challenges. This state of equilibrium could be achieved through the education and promotion of awareness amongst the back injured individuals as well as stakeholders such as the medical sector and business sector. It is within this context that Health Promotion is viewed as a method of building healthy public policies throughout the world.

2.7 Health Promotion

The World Health Organization (W.H.O) defines health as a state of complete physical, mental and social well-being, not merely the absence of disease (W.H.O, 1986). It is from the above perspective that health promotion with its strategies of re-orientating health services by creating cost effective rehabilitation models plays an instrumental role in remediating the back injured individual.

Voit (2000), in her analysis of health and fitness programmes, explains that health promotion programmes can have a lasting positive effect on both employer and employee. She further explains that employers would benefit from these

programmes; as they would reach a greater number of at risk employees such as back injured individuals. These benefits may become evident in decreasing absenteeism in the workplace as well as saving employers' money with regard to the loss of productivity. According to Myers et al (1999), the levels of stress experienced by workers could be minimised by allowing them to develop self-control over their work tasks in order to prevent injuries within the workplace. Methods of facilitating this process would be through worksite health promotion strategies such as health education classes, stress management, nutrition, weight loss and smoking cessation clinics. A recent survey facilitated by Buchbinder (Mass media health campaigns, 2001), focused on improving the public's knowledge of back pain by implementing a health promotion approach whereby mass media campaigns were utilised. In this study, the public's beliefs and attitudes became more positive, and the rates of back pain compensation claims were dramatically reduced. Although various models have been proposed for successful return to work after a back injury, minimal research has been conducted in the area of health promotion in controlling or minimising back injuries. Research has indicated that costs and time loss injury claims are continuing to rise and it is not clear why there is not a higher success rate in returning the back injured individual to work (Hazard, Ried & Clark, 2000). Therefore, an exploration of the back injured individuals' perceptions and experiences of returning to work needs to be undertaken in order to develop recommendations for a return to work model.

2.8 Conclusion

The review of the literature has indicated that few research studies have taken the back injured individual's perceptions and experiences into consideration with the goal of developing more comprehensive rehabilitation programmes. It is essential that the individual's return to work process be understood from their personal perceptions and experiences. It is within this context that the study will depart by investigating the challenges that back injured individuals face in adapting to their worker roles.

3. Chapter Three: Methods

3.1 Aim

The aim of the study is to explore back-rehabilitated clients' perceptions and experiences of the challenges they face in adapting to their worker roles.

3.2 Objectives

The objectives of the study are as follows:

1. To investigate the barriers that hinder back rehabilitated client's adaptation to their worker roles.
2. To investigate the factors that facilitate back rehabilitated client's adaptation to their worker roles.
3. To investigate back rehabilitated client's perceptions and experiences of their adaptation to their worker roles.
4. To provide recommendations for the development of a model that will facilitate re-integration to work, which will serve as a basis for programme development.



3.3 Research Paradigm

3.3.1 Qualitative research

According to Kielhofner (1997) disability is a personal matter that is uniquely experienced by each individual. Therefore, the experiential world of the patient or client should be the focal point of the therapeutic process. According to Roozee (1990), low back pain is viewed as having a myriad of symptoms and related disabilities and as the syndrome is such a complex one it is best dealt with by a range of professionals. The multi-dimensional nature of chronic back pain requires an approach that holistically addresses the condition. According to Bailey (1997) qualitative research describes multiple realities and interpretations aimed at developing an in-depth understanding of the perspectives and experiences of the actors. It is for this reason that a qualitative research paradigm was chosen in order to conduct the study.

3.3.2 Phenomenology

The research aim requires that a qualitative phenomenological approach be taken because the emphasis is to describe phenomena i.e. perceptions and experiences of back injured workers returning to work. These perceptions and experiences are embedded within a specific socio-cultural context. The individual's subjective experience or perceptions of phenomena is regarded as authentic and is based on a socially constructed reality (Finlay, 1998). This approach aims to describe and explore the meaning that subjects give to their everyday lives. This could be accomplished when the researcher is able to enter the participant's world of reality and place him/herself in the shoes of the subject (de Vos et al, 1998).

3.4 Data collection technique

3.4.1 Focus groups

The technique chosen for collecting data was that of focus groups. Wilkinson (1998) explains that due to the interactive nature of focus groups they are an ideal method for exploring people's own meaning and understanding of issues such as health and illness. Therefore, focus groups can be particularly helpful in programme development research, which is developed from the perspectives and experiences of the participants who will benefit from the research. Wilkinson (1998) also states that this method of research is particularly useful for assessing the views of those who have been poorly served by traditional research (e.g. the unsatisfactory treatment outcomes amongst back injured individuals). It is therefore argued that focus groups place the participants in a favourable position to be involved in further research techniques such as action research, which could aid possible future programme development.

3.4.2 Pilot focus group

In qualitative research, pilot testing can be viewed as a method of investigating interview questions and demographic questionnaires prior to the actual interviews (Gallew & Mu, 2004). Pilot testing is seen as a prerequisite for the successful execution and completion of a research project. It allows for the tentative planning, clarification of the research problem and forms an integral part of the research process (Strydom, 1998).

A pilot focus group was conducted in order to familiarise the researcher with the data collection process as well as to refine the semi-structured questions. This also served as a guide from which to determine the various approaches necessary to explore the objectives of the study. As no problems were determined in the semi-structured questionnaire of the pilot focus group, minimal changes were made in the questionnaires of the focus groups that followed. The information collected from the pilot focus group was incorporated within the study as this contributed to the objectives of the study.

3.5 Participants

3.5.1 Gaining access to participants

The participants were selected from statistical records of the Rehabsa Work Rehabilitation and Assessment Centre, and the Occupational Therapy Department Work Assessment Unit at Tygerberg Hospital.

The company called Rehabsa is situated on the Ground Floor in the Libertas Medical Centre, Goodwood, Cape Town, South Africa. As it is one of the only known private rehabilitation areas operating within Cape Town they were ideal for the selection of work- injured patients for the study. As a range of patients with various conditions is seen at the centre only patients with back injuries were selected from the 2002 statistical records of Rehabsa.

Tygerberg Hospital is a tertiary hospital situated in the Tygerberg Municipal area of Cape Town. Back injured clients who were assessed by the Occupational Therapy Department, for the year 2002, were selected from statistical records for the study (see pg. 22 for the section on sampling).

The participants were telephonically contacted at their places of employment, if they were employed and at their residential addresses if unemployed. The purpose of the research was telephonically explained to them and if they had a fax machine the explanatory information was then faxed to them (see Appendix B). The participants who arrived for the focus group sessions were then re-informed about the project and were given a chance to withdraw their consent before participating in the research focus groups.

3.5.2 Sampling

“Sampling can be viewed as a subset of measurements drawn from a population in which we are interested” (Strydom, 1998:191). It is seen as a method of gaining understanding about a given population and can therefore be viewed as a procedure aimed at selecting a representative facet of the population in order to participate in a study.

According to Kerlinger (1986) simple random sampling is a method of selection that provides each member with an equal chance of being selected. Simple random sampling was therefore used as a method to provide each client, who was on the statistical records of Rehabsa and Tygerberg Hospital, an equal chance of being selected for the study. A table of random digits were utilised for selection purposes whereby a number was given to each name on the statistical records from Rehabsa Back Rehabilitation Clinic and Tygerberg Hospital Work Assessment Unit (sampling frame). An arbitrary starting point was chosen on the random table and the first 40 numbers with the corresponding names were chosen. The selected participants were then invited to participate in the study. The aim of the sampling strategy was to recruit a cross-section of participants who were typical of the type of patients treated at Rehabsa and Tygerberg Hospital. However this sampling method proved to be a limitation in the study (see the section on limitations of the study).

3.5.3 Size of the study and incentives to participants

Krueger (1994) argues that the ideal number of participants of a focus group should be between six and nine. A group of 40 participants were selected for involvement in the six focus groups. However, due to transportation difficulties and work commitments, on average only four individuals participated in each focus group session. Participants who came more than one hour late were asked not to participate in the group discussions. These individuals were compensated financially and could either leave immediately or enjoy some coffee. They were also invited to participate in future focus group sessions. According to Steward and Shamdasani (1990) incentives in the form of snacks, transport money and baby sitters are of great value in ensuring participation. Participants in the current

study were telephonically informed of the incentives the night before the focus group discussions.

3.5.4 Evolution of sampling criteria

All of the participants had experienced some form of rehabilitation for their back pain and were currently or had been previously involved in some form of employment. Participants were included in the study regardless of the areas where they resided. Random selection enabled the researcher to select individuals that were from different race groups and ages (see Table 1).

3.5.5 Inclusion Criteria

- Individuals had a medically diagnosed back problem.
- Individuals had to have some form of employment (i.e. work with remuneration) before and after the diagnosis.
- Individuals had received medical intervention and rehabilitation for their diagnosed back problem. Rehabilitation within the study either meant physiotherapy, and/or occupational therapy and/or work hardening.
- Individuals were in the age bracket of 18 years and older.

3.5.6 Exclusion Criteria

- Individuals were excluded if they had any form of psychiatric diagnosis according to the DSM-IV.

3.5.7 Excluded criterion

The following criterion was excluded before the selection of the sample:

- Clients must be in the age bracket 18-55 years.

The researcher's assumption was that participants' aged older than 55 years would be rendered non-productive and not employable. However, this criterion was discarded as individuals aged over the age of 55 brought with them a wealth of experience regarding their perceptions and experiences of adapting to their worker roles.

Table 1: Demographic and Medical Data for Participants

Key:

m - (male)

f - (female)

G - (pilot group)

T.H - (tertiary hospital)

D.H - (day hospital)

G.P - (general practitioner)

B.R.F - (back rehabilitation facility, back school)

Other- (includes any other type of treatment intervention)

Variable	Category	No. of participants in Pilot Group	No. of participants in Group Model One	No. of participants in Group Model Two	Total no. of participants in the study
Gender	Male	3	4	11	18
	Female	0	4	4	8
Age (years)		18-35=2(m) 36-60=1(m)	36-60=5(m) 36-60=3(f)	18-35=9(m) 36-60=1(m) 18-35=1(f) 36-60=4(f)	
Race	Coloured	2(m)	3(m), 4(f)	9 (m), 3(f)	
	White	1(m)	1(m)	2(m), 1(f)	
Employed	Yes	3	1(m), 1(f)	7(m), 1(f)	
	No	0	3(m), 3(f)	5(m), 3(f)	
Medical Intervention	Types of institutions where treatment was received	T.H.=1(m) B.R.F.=1(m) Other=1(m)	T.H.=3(m) 3(f) D.H=2(m) 2(f) B.R.F=2(m) G.P=3(m) 2(f) Other=2(m) 1(f)	T.H=4(m) 2(f) D.H=1(m) 1f) B.R.F=7(m) 2(f) G.P=2(m) 2(f) Other=3(m) 2(f)	
Data Collection	Number of focus groups	1 session	3 sessions	3 sessions (different participants per group)	

3.6 Procedure

The researcher facilitated the focus groups. A technician was present during the first two sessions to video-record responses. However, as the technical aspects of the study became more manageable the use of the technician was abolished. Thereafter, only audiotape recordings were utilised. One pilot testing group and six two-hour focus groups were conducted with an average of four participants attending each group.

Only three individuals participated in the pilot focus group. This caused the researcher to be concerned about the attendance of participants in actual focus groups. Therefore, two focus group models were utilised in order to ensure adequate participation and sufficient collection of the data.

In the first model the same group of participants were invited to attend the three groups. Out of the eight participants invited, four participated in all three focus group sessions. In each of the sessions a semi-structured questionnaire, which built on questions from the previous group/s, was used in order to seek deeper meanings in an attempt to answer the research question (see Appendix D). In the second model, a total of fifteen participants took part in the three groups. An average of four participants, participated in each focus group session. This model utilised the same semi-structured questionnaire for all three sessions (see Appendix E). It served the purpose for exploring the perceptions and experiences of a variety of participants, thus ensuring variation in the opinions of research participants.

The focus groups were semi-structured. Broad questions were asked and followed up with probing in order to elicit detailed and rich descriptions. A form of debriefing was incorporated at the end of each session, where participants were allowed to ask any questions they had as well as discuss their experiences of participating in a group.

3.7 Data collection

Data was collected by means of video taping two of the sessions and audiotape recording all of the six sessions. The researcher kept a reflective journal in which

field notes, his personal feelings regarding the study and reflections after discussions with supervisors were written. Audiotapes and field notes were transcribed in preparation for the analysis process.

3.8 Structure of area for conducting the interviews

The structure of the interview environment is of vital importance in preventing participants from being distracted and to free audiotape/video tape recordings from unnecessary noise (Cook, 2001). The focus groups were conducted in one of the consultation rooms in the Occupational Therapy Department at Tygerberg Hospital because of the familiarity of the venue to all the participants. The times of the groups were scheduled every two weeks on a Thursday afternoon as this time best suited participants. The participants were seated around a table to ensure good eye contact. Name tags were provided to establish rapport amongst participants. Refreshments were made available and participants could take their snacks to their seats where they made themselves comfortable. A video camera and audiotape were placed in a strategic position so that all the information obtained was free from irrelevant external stimuli. The focus group questions were presented to participants in English and Afrikaans.

3.9 Presentation of focus groups

Small talk was initiated the moment the participants arrived in order to create an atmosphere of trust, friendliness and openness. Participants were reminded of the issue of confidentiality and that they could leave at any stage during the group sessions.

An icebreaker was used in order to relax and familiarise participants with each other as well as the environmental setting. The researcher set the goals and objectives for the discussion and ensured participants that their opinions would be respected. The questions were discussed before hand with supervisors and changes were made as appropriate. Repeated discussions with the supervisors allowed the researcher to keep a clear focus, visualise the proceedings and appreciate the value of the participants` contributions. This enabled the researcher to be aware of the various group dynamics that played a role, such as the differences in cultural habits, values and beliefs. The focus group sessions were conducted every second

week for a period of 3 months. In order to ensure participation, individuals were telephoned the night before the sessions. After the completion of the six sessions, the participants were invited to participate in a member checking group. Specific participants were not selected as the researcher felt that all participants could contribute to the same extent.

3.10 Data analysis

3.10.1 The process of data analysis

The process involved the following steps: data management and thematic analysis.

3.10.2 Data management

The data was transcribed and translated verbatim by a professional transcriber. The data was managed manually using a cut and paste method for the coding process.

3.10.3 Thematic analysis

Creative and solid data analysis requires a relentless search for answers, active observation and accurate recall. It is the process of sorting and fitting data together, making the invisible obvious and connecting consequences (Morse, 1994). In the current study, four cognitive processes enabled the researcher to analyse the qualitative data i.e. comprehending, synthesising (decontextualising), theorising and recontextualising (Morse & Field, 1996).

3.10.3.1 The first phase of thematic analysis

Comprehending

The interviews were tape recorded with the consent of the participants. Immediately after the interviews, preliminary notes were written into the researcher's reflective journal. The original tape was taken to the transcriber. A verbal contract was maintained between the researcher and transcriber, which ensured that the confidentiality of information was maintained.

An Afrikaans first language speaking person, who was experienced in transcribing data into both the English and Afrikaans languages, transcribed the interview tapes. A system was developed whereby the transcriber would leave question

markers whenever she was unclear of something that the participants said or when there was auditory vagueness of the cassette. The transcriptions were completed immediately after the interviews, giving the researcher time to read and understand the interview data before proceeding with other interviews.

The process of bracketing enabled the researcher not to compromise the validity of the study. This was ensured through regular conversations with research supervisors. In order for the researcher to get a clearer picture of the interviewed data, the audiotape and the transcript of the tape were checked a number of times. This ensured that the transcription notes were accurate therefore enabling the researcher to visualise the experience of the participants.

The information was then coded via line-by-line analysis to uncover the underlying meanings in the text. Thereafter, the researcher was able to identify experiences that were part of the topic and patterns that predicted potential outcomes.



3.10.3.2 The second phase of thematic analysis

Synthesising

This stage of data analysis is reached when the researcher becomes intimately involved with the data. Indicators when this stage of synthesis is reached are when the information regarding the particular phenomena can be provided with confidence (Morse & Field, 1996). This stage was reached at the end of the sixth focus group. The transcriptions were compared during the analysis, where codes were developed into categories by means of commonalities, consisting of segments of transcripts.

3.10.3.3 The third phase of thematic analysis

Theorising

This stage involves the selection and classing of alternative theoretical models to the categorised data (ibid, 1996). Various explanations were examined against the data until the research data were best explained. Questions were asked about the data in order to establish links to theory. This systematic process enabled the researcher to inductively develop formal themes from the data. It also enabled the

researcher to identify the characteristics of the data that contributed to a specific experience or perception. During this phase in-depth conversations were held with supervisors as well as the postgraduate research group at the University of the Western Cape in order to develop the accuracy of common and emerging themes.

3.10.3.4 The final phase of thematic analysis

Recontextualising

The comparison of similarities and differences between the data and published work of other researchers and recognised theory played a crucial role in ensuring the credibility of the data. The researcher attempted to place the results of the research in the context of established knowledge and identified results that supported the literature or claimed unique contributions.

3.11 Bracketing

The researcher assumed that the participant's gender and race would negatively influence their level of participation in focus groups as well as the findings of the study. Another assumption was the researcher's view of the negative influence he would have on the responses of participants as he treated many of them in the occupational therapy department. The researcher's assumptions and pre conceptions were highlighted and controlled by means of bracketing.

To bracket means to suspend or lay aside what is known about the experience being studied (Burns & Grove, 1987). The researcher eliminates preconceived ideas and constructs, this therefore enables him to see all facets of the phenomenon and therefore leads to the formation of new constructs.

Through constant discussions and feedback from supervisors the process of bracketing was incorporated. These sessions required that the researcher reflect on past experiences of being a professional, working with clients with back problems and therefore analysing reasons/motivations for exploring the perceptions of back injured individuals when entering their worker roles. This enabled the researcher to ponder upon his views and enabled him to rigorously examine the research process. The researcher's experiences and feelings were entered into a journal throughout the data collection and data analysis stages. These journal entries were

therefore viewed as a method of self-realisation and debriefing. This enabled the researcher to separate his subjective experiences, from that of the participants. Bracketing thus guided the researcher throughout the analysis process whereby he could control his own biases especially when setting up the focus group questionnaire guides.

3.12 Establishing trustworthiness

Trustworthiness refers to the ability of the researcher to ensure rigour of qualitative designs without sacrificing the relevance of the qualitative research (Guba, 1981). In this study trustworthiness was ensured, by recording an audit trail throughout the research endeavour so that the reader could follow the decisions made throughout the process to its final conclusions (Rodgers & Cowles, 1993).

The following techniques were used in order to ensure credibility and trustworthiness of data:

3.12.1 Member checking



Member checking involved checking the data with the participants to make sure that the data was authentic to their experience. Here the participants were able to clarify points that they felt were poorly presented while confirming other descriptions and explanations about their perceptions and experiences of returning to work. Discussions with regard to the initial interpretations of the categories and sub categories and possible conclusions were discussed with the members. Any changes or suggestions from the participants were then further analysed and incorporated into the study.

3.12.2 Peer debriefing

Peer debriefing was achieved through consultations with peers and supervisors regarding data analysis and conclusions of the study. Different parts of the study were presented to the Occupational Therapy Department at the University of the Western Cape for discussion. This critical evaluation provided the researcher with new insights and confirmed his conclusions.

3.12.3 Triangulation

According to Gliner (1994) triangulation can be seen as a means of establishing different patterns of agreement based on more than one method of observation, information gathering, or the use of more than one data source in order to establish credibility.

In this study triangulation was achieved through videotapes, audiotapes and transcriptions of focus groups, a reflective journal, and verification of data by available literature and peer reviews.

3.12.4 Transferability

This refers to the degree that the study could be applied to other contexts or to other groups of participants (Krefting, 1990). The study aimed to describe the perceptions and experiences of back injured individuals when returning to work. The findings were not intended to be generalised to the entire population of back injured individuals, but rather to highlight various ways of viewing the back injured individual from a multidimensional point of view. The decision trail implemented in the study is clearly detailed within the current thesis and thus enables the reader to decide on the quality of the findings and its applicability to other similar contexts.

3.12.5 Dependability

Dependability refers to the consistency of the findings if the study was to be replicated within a similar context (Krefting, 1990). The study is regarded as credible when the results of the study are considered to be dependable. The dependability within the current study, was enhanced by describing the theoretical, methodological and analytical processes involved in completing the study (ibid, 1990). Dependability was achieved within the study through the use of an audit trail.

3.12.6 Confirmability

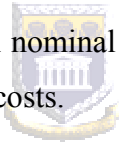
This refers to the findings of the research as being purely from the perspectives/experiences of the informants and conditions of the research and not due to other biases (ibid, 1990).

Confirmability was made evident by the use of the member checking group, as well as the rich descriptions presented in the discussions on the various topics, therefore enabling the reader to follow the research process as well as the conclusions that were reached.

3.13 Ethics

Informants were telephonically contacted whereby the aim, purpose and process of the study were highlighted to them. The information was faxed to their places of employment and if they were unemployed the details together with the consent forms were fully disclosed to them on arrival at the interview session. Details with regard to the time frame and all the issues concerning confidentiality were discussed with them.

The participants were informed about the purpose of the research and it was explained that copies of the research would be made available to the Department of Health and the University of the Western Cape and published in an Occupational Therapy Journal. A nominal monetary fee of R50, 00 was provided to participants to cover transport costs.



3.13.1 Obtaining consent for the study

The Faculty of Community and Health Sciences' Higher Degrees Committee from the University of the Western Cape was approached before commencing with the study. They approved the research proposal in October 2002.

3.13.2 Debriefing amongst group members

The participants were reassured that no harm would befall them. This resulted in the swift control of sensitive issues such as employer and employee conflict. The researcher remained sensitive to the feelings of participants by responding to cues that enabled the researcher to support their emotional expressions whether verbal or non verbal. Participants were assured that they could contact the researcher at any stage during or after the research study where contact telephone numbers of resources such as the Help Desk of COIDA were made available to them.

3.13.3 Confidentiality

The principle of confidentiality requires that the dignity of interviewees be respected. Interviewees were assured that their identities and any information that they provided would be treated as confidential (Schurink, 1998). In this study, the participants preferred to be referred to as the participants or he or she in the written report. Their consent was obtained to audio-tape as well as video-tape the interviews. It was emphasized that the audiotapes were to be used only for the transcriptions and would be destroyed after the study was completed. They were assured that the transcriber/typist was a professional and that she would view all information with the utmost of confidence.

3.14 Limitations

3.14.1 The nature of the condition

Although most participants complained of low back pain, their back injury was not limited to a specific area of their spine (i.e. cervical, thoracic and lumbar spine). Some participants had additional injuries such as fractures due to accidents that they had been involved in. This could have negatively impacted on their work abilities in addition to their back injuries. However, the description of the factors that impacted on their worker roles were validated by their experience/s.

3.14.2 Cultural factors

Although every effort was made to include all ethnic groups, delays with regard to transportation, family problems and work commitments prevented individuals from participating in the focus groups. Individuals from the black (Xhosa speaking) race group were not represented within the focus groups as they had transportation problems. It is felt that for future studies, individual interviews should be conducted with those individuals who find it difficult to participate in focus groups. The individuals that were randomly selected had one factor in common i.e. back pain. This provided a common thread for them to initiate discussions. However, according to observations, it was noticed that some of the white participants were hesitant in providing their perceptions and experiences especially when it involved concepts such as the effects of “apartheid on the worker role”. It is assumed that this limited their true perceptions and experiences on certain topics presented due to their political beliefs. In this study it was of vital

importance to get as wide and in-depth an opinion as possible and therefore it was essential for the researcher to have good facilitating skills to limit dominant speakers. Individuals that were hesitant in speaking were encouraged but not forced. This contributed to improved trust and more complete participation in the data collecting process.

3.14.3 Gender factors

One of the researcher's assumptions was that males traditionally, in general, do not show their emotions when compared to females. However, in this study the males and the females contributed equally because the topic of discussion was something they could relate to and the focus groups presented participants with the opportunity to vent their frustration. At times there were sensitive topics that caused participants to become emotional; however, this was controlled when the males and females in the study comforted each other. Some males mentioned that they would have contributed information at a deeper level if there were individual interviews in addition to the focus groups. It would therefore be useful to conduct in-depth interviews together with group discussions in order to elicit more information in future studies. However, for the purposes of this study it was felt that saturation was achieved as both focus group models used in the study presented with similar findings.

3.14.4 The sampling strategy

Simple random sampling limited the diversity and the variation of responses amongst research participants. It is felt that the research question could have been answered in greater depth if methods such as maximum variation sampling or purposive sampling had been used.

4. Chapter Four: Findings

4.1 Background information of participants

Every effort was made to select as diverse a set of participants as possible. However, due to unforeseen circumstances not all race groups participated in the study, and therefore only four white individuals (3 male & 1 female) participated, while the rest were individuals from the coloured race group (see Table 1). For purposes of this study ‘coloured’ refers to individuals derived from Asian, European, Khoisan, and African ancestry according to the Population registration Act of 1950 (Population and Registration Act, online, 2004). Perspectives from the black race group in the study were non-existent, as this population was not represented. Even though three black individuals were selected they were unable to participate on the day of the study due to transportation problems.

4.2 Themes

The themes of the study explore the challenges that back rehabilitated clients face when returning to work and are directly related to the study objectives. Theme one relates to the barriers that hinder the back injured clients’ adaptation to their worker roles and theme two relates to the facilitators that aid clients in adapting to their worker roles. Theme three relates to the clients’ perceptions and experiences of adapting to their worker roles whereas theme four relates to the clients’ perceptions and experiences of an ideal return to work model.

The following themes emerged from the analysis of the data:

Theme One: Feeling Doubted: “Is jou rug regtig so seer?”

Theme Two: A team effort: “Ek is gelukkig in die werk omdat ons almal verstaan die situasie en ondersteun mekaar.”

Theme Three: Responsibility for self: “Ek moet agter myself kyk.”

Theme Four: Moving towards an ideal programme: “Nou wat soorte program sal my werk en gesondheid bly hou?”

Each theme is discussed in terms of its categories and sub categories. The participants' quotes are presented in italics. Original Afrikaans quotes are followed by the English translation where applicable.

4.2.1 Theme One - Feeling Doubted: *“Is jou rug regtig so seer?”* *“Is your back really so painful?”*

This theme describes the doubt that stakeholders had towards the participant's or back injured^a individual's condition and how this was interpreted as a barrier* that impacted on the individual's life. The theme is indicative of how this barrier was internalised by the injured worker and how this resulted in a perception of self-doubt or inefficacy in the individual's own personal abilities. These negative perceptions were reinforced by negative experiences of the back injured individual within the workplace and within the medical environment. This resulted in the participants having doubt not only in the opportunities in the environment but also having doubt in their fulfilment at work. As one participant explained:

“Is jou rug regtig so seer?”



“Is your back really so painful?”

The quotation was interpreted figuratively whereby the individual's employer and colleagues expressed doubt about the individual's pain and limited functional capacity. The doubt of back injured individuals in vocational opportunities within the work environment caused feelings of dissatisfaction amongst them. Participants felt the need to express their frustration, as they perceived themselves as being alone within an unsupportive environment with a disabling condition that affected every aspect of their life.

*Barriers referred to those perceptions or experiences of participants that prevent or negatively influence participation of participants in the return to work process.

^aFor purposes of the text the phrase back injured individual and the phrases back injured worker, individual or participant will be used interchangeably.

Table 2

4.2.1 Theme One- Feeling doubted: "Is jou rug regtig so seer?"			
4.2.1.1 Category One Feeling doubted by stakeholders	4.2.1.2 Category Two Self-doubt	4.2.1.3 Category Three Doubting opportunities	4.2.1.4 Category Four Doubt in own potential for fulfilment at work
<p>4.2.1.1.1 Employer developing an unsympathetic attitude and doubt in the back injured employee</p> <p>4.2.1.1.2 Medical profession developing an unsympathetic attitude and doubt in the back injured individual's condition</p> <p>4.2.1.1.3 Family and society developing doubt in the back injured individual's condition</p>	<p>4.2.1.2.1 Doubt in function and abilities as a result of pain</p> <p>4.2.1.2.2 Doubt in functional recovery due to depression and osteoarthritis</p>	<p>4.2.1.3.1 Doubting work retraining</p> <p>4.2.1.3.2 Doubting the efficacy of surgical treatment</p> <p>4.2.1.3.3 Doubting promotional opportunities within the workplace</p> <p>4.2.1.3.4 Doubting workplace policies</p> <p>4.2.1.3.5 Doubting safety of the working environment</p>	<p>4.2.1.4.1 Doubt in return to work strategies</p> <p>4.2.1.4.2 Doubt in accommodation within the workplace</p> <p>4.2.1.4.3 Doubt in the communication structures of authorities</p> <p>4.2.1.4.4 Doubt in finding meaning in the worker role</p>

4.2.1.1 Category One: Feeling doubted by stakeholders

The category of “feeling doubted by stake holders” explains the unsympathetic attitude that stakeholders, such as the employer, medical profession, family and society had in the participant’s medical condition. Stakeholders interpreted this unsympathetic attitude as a perception of doubt in the participant’s back pain.

The stakeholders that were either directly or indirectly in contact with the back injured individual had a significant impact on their perceived abilities. The doubt expressed by the stakeholders in the back injured workers` functional abilities and back pain caused the injured worker’s self-concept to become negatively affected. This doubt resulted in co-workers not only ignoring but also not relying on the back injured workers and thus causing them to be uncomfortable in the workplace. One participant explained the latter by saying:

“Hulle sê nee moenie worry nie ons verstaan en so aan maar naderhand kan jy agter kom, soos hulle sluit jou uit dinge uit, van hulle weet dat hulle kan nie op jou pyl trek nie.”



“They say don’t worry we understand and so on, however after a while you get the feeling that they are not involving you in things, because they know they cannot depend on you.”

4.2.1.1.1 Employer developing an unsympathetic attitude and doubt in the back injured employee

The category is indicative of how the unsympathetic attitude of the employer was perceived as a sense of doubt in the participant’s back pain. The participants felt that this attitude caused them to work in unbearable circumstances. A lack of sympathy would be displayed in the type of work that was allocated to the worker after the injury and was used at times as a motivator to expel the worker. Relationships between the employer and the employee deteriorated as a feeling of distrust developed. Participants felt that employers were not concerned about the employees and viewed them as replaceable.

During staff meetings the injured workers' productive outputs were made apparent to the rest of the staff. As one participant said:

“Die baas wil vir `n mens net vervang, hy sal vir almal sê hoe swak die werk is dan kyk hy na jou.”

“The boss just wants to catch you, he will tell everyone how poor the work is then he looks at you.”

The employer's doubt in the individual's back pain developed to the extent that the employer disregarded or refused to comply with the medical practitioner's view of considering alternative workplace accommodation for the participants. One of the participants explained:

“Ek sien daar is ligter werk maar hy sê daar is nie ligter werk nie. Hy weet die dokter het my op light duty gesit maar hy luister nie.”

“I see there is light duty however he says that there is no light duty He knows that the doctor has put me on light duty but he does not listen.”

Experiences such as these indicated in the above quotes led to the participants' perceptions of doubt particularly if employers failed to reasonably accommodate workers. One participant explained that the employer was not concerned about the pain that he experienced rather he was seen as a “working horse” without any emotions or feelings. The participants therefore developed the perception that the employers lacked sympathy and did not believe that they suffered from a back condition. As one participant said:

“Hy is nie bekommerd watse pyn jy het nie jy is maar amper soos `n donkie.”

“He is not worried about the pain that you have, you are almost like a donkey.”

Participants felt that they could no longer take the pain and the consequent problems that followed at work. One participant was of the perception that the employer had an unsympathetic attitude towards her as he was waiting for her to give in her resignation because she was seen as a burden to the company. She said:

“Ek kan dit nie meer gavat het nie, om kennis te gee nou, daarvoor het hulle gewag.”

“I could not take it anymore, to give notice now, that is something they have been waiting for.”

One participant felt that he had to constantly sacrifice his own well being by allowing the employer to shift him to any position at work that the employer deemed suitable for him. These actions of the employer were perceived as an unsympathetic attitude towards the participant's medical condition. He said:

“Ja okay soos ek wat nou in die polisie is, daars basies kan hulle jou skuif wherever hulle wil. Hulle is nie geworried van jou toestand nie.”

“Yes, okay like myself that is currently in the police force, they can shift you basically wherever they want. They are not worried about your condition.”

Within the work environment, participants felt that co-workers and supervisors had limited knowledge of their injury. Participants felt that this reinforced unsympathetic attitudes towards them. As one participant explained:

“Tweede in die werks plek is daar baie min mense wat kennis dra van my besering. Ek dink hulle wil dit net nie glo nie.”

“Secondly within the workplace, there are very few people that have knowledge of my injury. I think that they just don't want to believe it.”

4.2.1.1.2 Medical profession developing an unsympathetic attitude and doubt in the back injured individual's condition

One participant explained that although he went to the doctor for help, he was disappointed, in that the doctor did not believe that he was experiencing pain. This was perceived as a perception of doubt that the medical professional had when assessing the participant's medical condition. He said:

“Jy voel seer dan is hulle en die dokter om vir jou te sê dis alles in jou mind in, jy makeer niks.”

“You feel sore then they are the one together with the doctor to tell you that it is all in your mind and that there is nothing wrong with you.”

The poor financial status of the participants often resulted in their perception that physicians were stigmatising them, as they could not pay for the health services they received. Participants explained that physicians had the tendency to make them feel guilty about the money that the organisation Workman's Compensation owed them. This caused the participants to not assert themselves by means of not questioning the quality of treatment that they were receiving.

As one participant explained:

“In my mind in dat die dokter wag ook lank vir sy geld hy so siek en sat nou dat hy sit jou brein nou op geld dat jy nou nie moet complain oor die behandeling wat jy kry nie.”

“In my mind I know that the doctor waits a long time for his money, he is so frustrated that he focuses your brain on money that you should not complain about the treatment that you are receiving.”

The participants developed a sense of frustration with the medical system, as the pain they were experiencing could not be validated by formal assessment methods such as X-Rays. Participants felt that this lack of validity reinforced the physician's doubt in diagnosing their back pain. As one participant explained:

“Elke keer kom ek terug dan sê hulle vir my jy makeer niks, die X-strale makeer niks. Ek kry naderhand die gevoel dat hulle glo my nie.”

“Everytime I come back then they tell me that there is nothing wrong with me, the X-Rays indicate no problems. I got the feeling that they do not believe me.”

Participants felt that due to the complicated nature of diagnosing the back injury, the physician used non-standardised or unorthodox methods to determine whether the individual was malingering. As one participant explained:

“Nou sê jy vir hom (dokter) jou rug is seer nou sê hy vir jou sit. Nou skielik laat val hy sy pen verstaan...daai was hulle taktiek gewees.”

“Now you tell him (doctor) that your back is painful, then he says that you should sit down. Then suddenly he drops his pen understand....that was their tactics they used.”



4.2.1.1.3 Family and society developing doubt in the back injured individual's condition

Participants were of the perception that society measures an individual's worth in terms of what the individual can financially contribute to society. If problems arose in the household as a result of an individual not being able to fulfil the various roles of a home-maker and breadwinner then it was perceived that the family members would be unsympathetic towards the back injured individual. This is evident in the following:

“I am no longer cared about in society, they don't see you because the only thing society sees today is money. I am divorced from my wife because of my medical problem because we struggled.”

One participant remarked that she was ashamed of her condition in that she constantly had to carry tablets in her handbag. She felt as if society was developing the perception that she was malingering. She said:

“Jy't altyd pille in jou handsak jy voel naderhand skaam daaroor. Jy begin dink dat die mense dink jy verbeel jouself.”

“You always have tablets in your bag after a while you become ashamed of it. You begin to think that people think you are imagining yourself.”

Society tended to view back problems with doubt and no empathy. Participants felt that society viewed them as malingering as they were not seen as physically disabled such as being in a wheel chair. As one participant explained:

“ Jy's gesond, jy is nie in roelstoel nie jy kan nog iets doen. Die mense daar byte dink so.”

“You are healthy, you are not in a wheel chair, you can do something. The people outside thinks this way.”

4.2.1.2 Category Two: Self-doubt

The category of “self-doubt” explains the back injured individual’s doubt in his or her function and ability as a result of back pain. It also explains how the development of secondary medical complications such as depression and osteoarthritis limited the back injured individual’s functional ability. The participants expressed frustration at the unpredictable nature of their condition. This caused many individuals to lose confidence in their abilities thus reinforcing the perception of self-doubt. As one participant explained:

“Ek weet dat ek kon beter in my lewe gedoen het, ek kon verder gewees het as dit nie vir my rug was wat my terug gehou het nie. Nou weet ek nie meer wat ek kan doen nie.”

“I know that I could have done better in my life, I could have been further if it was not for my back injury that kept me behind. Now I don’t know what I can do anymore.”

4.2.1.2.1 Doubt in function and abilities as a result of pain

Individuals tended to develop a fear or avoidance defence mechanism in order to avoid reinjury during activity participation. This fear of reinjury caused individuals not to participate in work tasks thus causing them to doubt themselves. As one participant explained:

“Ek dink ek doen iets goed maar ek maak myself seer. So ek vat nie `n kans om my beste te probeer nie.”

“I think that I am doing something good but I'm hurting myself. So I am not taking a chance to try my best.”

The participants perceived back pain as being out of their control as they regularly experienced relapses. This often impacted on their worker roles and their functional abilities to execute tasks within the workplace. The frustration they experienced resulted in them developing a perception of doubt in their abilities, for example when solving problems in difficult situations.

As one participant explained:



“...it was beyond their (participants) control. It was beyond my control of getting hurt... you become sick of the situation that you just walk out and you never walk back or you do something irresponsible.”

The individuals' functional abilities were compromised as the pain that they experienced became aggravated by cold temperatures and with strain. The strain individuals described was the strain experienced in their back when they participated in repetitive work tasks. One participant said:

“Nou pla jou rug vir jou hy kan nie te veel koue vat nie, kan nie te veel strain vat nie. Jy voel dan die pyn as jy aanhoudende werk doen.”

“Now your back is bothering you, it cannot take the cold temperatures, cannot take too much strain. You feel the pain as you are doing continuous work.”

Pain impacted on all the tasks that the participants were engaged in. The participants were of the opinion that they experienced pain throughout the day and they emphasized it as being present in all aspects of their lives.

“Met als wat ek optel en enige dinge ek gaan slaap met die pyn ek staan op met die pyn dit is net daar..”

“With everything that I am picking up and everything, I’ll go to sleep with the pain and I wake up with the pain, it is just there..”

Back pain impacted on their participation in activities of daily life by limiting the participants’ walking and standing endurance. Participants became frustrated with themselves in that they could not execute basic self-maintenance and work tasks. They would experience these delays in preparing for work in the morning and more importantly in completing the various tasks at work. As one participant explained:



“..maar as jy self nie vir jou kan aantrek nie dan is dit jy voel frustrated because jy kan niks vir jouself doen nie. Ek kan som take by die werk doen maar sukkel met meerste van hulle.”

“..if a person cannot dress yourself then you feel frustrated because you cannot do anything for yourself. I can do certain tasks at work but struggle with the majority of them.”

4.2.1.2.2 Doubt in functional recovery due to depression and osteo-arthritis

Depression was seen as a result of maladaptation to stress and pain. Depression impacted severely on the individual’s ability to execute their daily work tasks and sometimes caused them to seek professional help from a physician.

One participant said:

“..van kyk ek was by die dokter vir senuwees....ek is in `n depressie wat maak dat ek nie meer kan funksioneer nie..”

“ I was by the doctor for nerves...I am in a depression that does not allow me to function anymore..”

The back injured individual's condition became complicated with the development of additional diseases such as osteoporosis. The participants were of the opinion that even though they went for therapy, there was minimal relief from pain as a result of osteoarthritis. Doubt in their own ability was reinforced as individuals feared developing osteoarthritis. She said:

“Waarom die man (pasient) nie reg kan kom nie al doen hy hoeveel terapie, is dat die therapist weet nie dit is iets soos osteoporosis. Hy het dit in die beenstruktuur maar niemand het dit geskryf nie.”

“The reason why the man (patient) cannot become cured even though he undergoes therapy, is that the therapist does not know that it is something like osteoporosis. He has it within the bone structure however nobody has written it down.”



4.2.1.3 Category Three: Doubting opportunities

The category of “Doubting opportunities” explains the back injured individual's doubt in opportunities within the environment to improve their personal circumstances. This was expressed by means of the individual's doubt in work retraining as well as their doubt in the efficacy of surgical treatment for their back injuries. Emphasis would therefore be placed on the individuals doubt in opportunities within the workplace as a direct result of unsatisfactory work policies and unsafe working environments. The category describes the participant's doubt in opportunities due to employers discriminating against back injured individuals. Opportunity was defined by the participants as mechanisms that improved the participant's promotional chances within the work sector. One participant felt that even though he had put in so much effort to apply for a job it was hopeless as the employer contacted the hospital in order to investigate the extent of his back injury. He said:

“Kyk ek het gaan aansoek doen by die Kelners, maar ek moes so baie geloop het om `n kontrak te kry. Maar toe ongelukkig kontak hulle vir Tygerberg en Tygerberg sê ek het `n probleem. Verstaan. So jou deure slat vir jou toe..”

“Look, I had to apply by the Winery, but I had to walk for a long time to receive a contract. But unfortunately they contacted Tygerberg and Tygerberg said that I have a problem. Understand. So your doors are closing everywhere..”

4.2.1.3.1 Doubting work retraining

The participant explained that the employer tended not to care about him even though he was faithful by being a productive worker before the injury. He felt that his employer was angry with him now that he was struggling to produce the same quality and quantity of work. This caused individuals to doubt their ability to retrain themselves when returning to work after their back injuries. Participants were of the perception that retraining the individual was not beneficial to the company in terms of profit making. The participant said:

“Ja en uh hulle weet uh jy het die werk gedoen maar nou kan jy dit nie meer doen nie. Nou kyk hulle bo oor jou kop.”



“Yes and they know that you had done the work however you cannot do the work any more now they are looking over your head.”

Complications in terms of the repayment of medical bills were seen as a time consuming process whereby the injured had to decide either to repay rehabilitation facilities themselves or to wait for feedback from the employer regarding payment. The delay in repayment often caused individuals not to complete rehabilitation programmes and therefore reinforced an unsuccessful return to work rate. As one participant said:

“Hulle het vir my `n ding laat teken dat as die werk nie betaal dan sal ek dit betaal. Ek kon nie my program voltooi nie omdat ek nie geld gehad het nie, daarom sukkel ek nog steeds by die werk met die rug.”

“They made me sign a thing which states that if the work does not pay them, then I’ll be liable. I could not complete my programme because I did not have the money, that’s why I am still struggling at work with my back.”

The discontinuation of rehabilitation services caused individuals to doubt their ability to resume their full work capacity. One participant explained that she was in debt with her physiotherapist. As she could not pay for the services, she could not continue with treatment. She said:

“Ek het nou jys by L. (physiotherapist) hulle, ek skuld `n bedrag van R7000..nou kan ek nie fisio kry nie. Ek sit nou met `n chroniese probleem wat my werk affecteer.”

“I am currently in debt with L (physiotherapist), I owe them the amount of R7000 therefore I cannot continue with treatment. I am sitting now with a chronic problem that affects my work.”



Poor administration within the workplace was viewed as a barrier in that it often delayed rehabilitation and work retraining. The participants were of the perception that employers purposefully lost Workman’s Compensation reports which illegitimised the employees’ claims. One participant explained that she became frustrated with her employer in that her rehabilitation procedures were not approved due to poor administration. She said:

“ ..soos jou vorms wat weg raak, daai goeters jy weet jys reeds in pyn. Ek dink hulle verloor dit aspris, van hulle weet jy sal nou nie kan weg van die werk bly om na die fisio te gaan nie.”

“..like your forms that are getting lost, you know then you still have pain. I think they do it purposely because now they know that you cannot stay away from work to attend physio.”

4.2.1.3.2 Doubting the efficacy of surgical treatment

Participants expressed a perception of doubt in the physician's techniques when diagnosing their back problems. Insufficient information and inappropriate assessments of their medical conditions resulted in a waste of the participant's time and already limited finances. As one participant explained:

“Ek is nou so siek en sat van die dokter se onsekerheid as hy vir my sien. Een dokter sê die is verkeerd dan sê `n ander dokter nee daai is verkeerd. Ek dink hulle wil net geld maak.”

“I am so siek and tired of the doctor's uncertainty when he sees me. One doctor says that this is wrong then another would say no that is wrong. I think they just want to make money.”

One participant felt that her physician was dishonest in his explanation of the functional recovery that she would have after her spinal surgery. The participant explained that the pain that she experienced was more severe after the surgical operation (i.e. laminectomy). She said:

“Die dokter het my gesê dat my operasie gaan `n sukses wees. Ek is net nooit weer dieselfde nie en na die fisie toe het ek `n laminektomie gehad...wees net eerlik...”

“The doctor told me that the operation was going to be a success. I am just not the same again and after the fusion I had a laminectomy..just be honest..”

The above quotes indicated the doubt that the participants had towards the physician and surgical intervention particularly when the physician was inaccurate with regard to their prognosis.

4.2.1.3.3 Doubting promotional opportunities within the workplace

The employer's lack of empathy reinforced the doubt that the injured individuals had in promotional opportunities within the workplace. Particularly, when the employers tended to foster an uncomfortable working environment in an attempt to

dismiss the back injured individual from the workplace. This was evident in the following:

“Bestuurder care ook nie. Hy werk eerder in so manier om vir jou weg te werk. Hulle maak die werk omgewing baie onaangenaam daarom weet jy dat jy sal net bly waar jy is.”

“Manager doesn’t care either. He rather works in such a manner as to expel you from your job. They make the work environment very uncomfortable that is why you know that you will just stay where you are.”

The above quotes indicated that opportunities within the workplace were limited for individuals with back injuries. This caused the participants to develop doubt in vocational opportunities if they were honest to employers about their back condition.

Individuals felt that they could not work well within the workplace without some form of co-operation from the company’s staff. This co-operation could therefore be viewed as co-operation between the back injured individual and his or her employer, and co-workers. As one participant explained:

“With minimum what can I say co operation from management in the company and this is what they do. In the workplace your fellow workers made it clear that you are on your own.”

The lack of co-operation between the back injured individual and the rest of the work staff fostered an unsupportive working environment. This resulted in individuals feeling alienated and eventually developing doubt in vocational opportunities.

Participants that sought employment developed the perception that they were not needed. One participant explained that it was emotionally painful for him because he could not find employment due to his injury. He said:

“Dis seer man, maar jy kan nêrens, wat jy probeer slat die deure vir jou toe.”

“It is painful man, because everywhere that you try then the doors are closing for you.”

Profit making was seen as priority from a company’s point of view. The participants were of the perception that managers viewed them as not being economically viable to the workplace. Individuals felt that employment opportunities were limited if not impossible.

A perception of being easily replaced and not valued was the underlying feeling of individuals while they were employed. This resulted in the development of a poor self-concept that affected their ability to find meaningful employment. Individuals felt that they did not have the abilities to be productive in other employment settings. This poor self-image, portrayed by the back injured individual, caused them to lose hope in promotional opportunities. As one participant explained in the following two quotes:



“Watter nut het ek vir nog `n firma?”

“What do I have to offer to another firm?”

“Jy is elk geval useless en jou selfbeeld is naderhand `n nil..”

“You are anyway useless and your self-image is eventually zero..”

Participants were of the opinion that age was an important pre-requisite for vocational opportunities. If an individual was older, their chances of finding meaningful employment were limited, especially when an older worker had a back injury. As one participant said:

“Ah any tradesman that wants to go overseas to make a buck for two years must be under 26, 27 maximum 28 otherwise you don’t fall in line. If you are looking for

work and you are over the age of 30 and your have a back problem then you have a problem.”

The participants felt that according to their physicians, the severity of their pain and reduced functional capacity was aggravated with an increase in age. This resulted in the employers stigmatising the back injured individual as they could be easily replaced by technology such as machines if they were unproductive.

As one participant explained:

“maar die dokter het nou gesê hoe ouer jy raak gaan dit erger, omdat jou rug swaaker raak. Dan het jy nog die problem van teknologie soos masjiene om saam te werk”

“but the doctor said that the older you become the worse it gets, because your back is getting weaker. Then you still have the problem of technology such as machines to work with.”



The participants mentioned that back injured individuals were not given a chance to prove themselves on the job because they did not have the necessary educational qualifications even though they had years of experience in doing their job tasks. As one participant explained:

“...toe sê ek oraait ek loop nie met klomp papiere rond nie. Maar ek het die werk vir lank jare gedoen. Op die eiende van die dag toe kry `n seun wat matrik voltooi het die werk.”

“..so I said okay I`m not walking around with a lot of papers. However I have been doing the work for a long period of time. At the end of the day a boy that completed matric got the job.”

Education was seen as crucial in the competitive world of employment especially in creating vocational opportunities. Participants felt that it was not what they knew in terms of their work experience, but rather their actual qualifications that

mattered. According to participants, entry level qualifications in the working sector had increased to such an extent that individuals needed more qualifications in order to do lower paid occupations. This therefore limited the vocational opportunity of poorly educated workers.

“..daar is mense wat jare werk maar dit gaan mos nie oor jou jare nie dit gaan oor jy wat kennis het, wat kwalifikasies het vir iets. Ek voel swak omdat ek weet ek sal nie die werk kry nie.”

“There are people that are working for years, but it is not about their experience it is about the qualifications that they have. I feel bad because I know that I will not get the job.”

4.2.1.3.4 Doubting workplace policies

The participants expressed the view that workplace policies which ignored the labour law, safety regulations and the health of the workers, contributed towards their physical incapacity. Participants perceived workplace policy to be less than satisfactory and doubted that it could benefit them in any way.

As one participant said:

“The unions are supposed to protect us people with injuries that we sustained in the workplace. Today we find that management will walk hand in hand with shopstewards that they have lunch together and management looks after the shop steward because you don’t know what comes in his envelope at the end of the week.”

The above quote indicated the participants’ view that union members were supposed to protect the injured employees however union officials were being financially bribed by employers. This therefore caused many participants to lose confidence in maintaining or resuming employment after the injury.

Participants perceived the policy of affirmative action as being a process that was similar to that of apartheid³ whereby only a select few received privileges, such as employment opportunities to obtain certain jobs. This policy of affirmative action

was perceived with a feeling of dissatisfaction by the back injured individuals who were from the coloured race group, because in addition to being discriminated against due to their back condition, they also had the additional racial issue to deal with. This precipitated feelings of frustration in these individuals when applying for work with another employer. As one participant explained:

“..u kan moes self sien - nou sien, die apartheid is nog nie klaar nie net omgedraai. Dit sê my al kla dat ek staan nie `n kans om werk te kry om dat ek `n kleur probleem en `n rug probleem het..”

“.. you can see for yourself that apartheid has not ended, it is only switched around. It already tells me that I don't stand a chance for a job because I have a colour problem as well as a back problem...”

4.2.1.3.5 Doubting safety of the working environment

Safety in the workplace was regarded as an important factor in maintaining the health of workers. Participants, expressed the need for safety officers, which could advocate on behalf of them, however, these individuals were not available.

“ Ten koste van die veiligheid van die werker, hou hulle daai goed weg dat daai mense nie opgelei is nie soos fire marshals en al daai tipe mense. Mense soos health officers in die werk is glad nie van gehoor nie.”

“To the detriment of the safety of the worker, they are keeping those things away, that those people are not trained such as firemarshals and all those types of people. People like health officers within the workplace are unheard of.”

“You suppose to have safety officers in the industry that specialise in different types of companies....so these people are not there.

³As part of its original formulation, apartheid sought to perpetuate white control over the developing economy in 87 per cent of South Africa by dividing the remaining 13 per cent into ten fragmented rural ‘homelands’ (Zille,1987)..

Safety clothes such as steel tip shoes and hard hats in heavy industry are seen as essentials in protecting the worker from injuries in the workplace. The participants emphasised the view that they were not receiving safety clothes and that the clothes they wore on the job were their own ordinary clothes. As one participant explained:

“so watse safety klere kry ek. Ek kry nie safety klere nie ek kry gewone klere.”

“so what safety clothing do I have. I don’t get safety clothing I get normal clothing.”

The quality of the safety shoes was also questionable as one participant replied that the shoes she wore had slippery soles when she walked on the floors at work. This exaggerated her fear of slipping and reinjuring herself. She said:

“..jy kry drie paar veiligheidskoene vir die jaar maar daai goed is net so glad.”

“ ..you get three pairs of safety shoes for the year but those shoes are just so smooth.”

The above quotes indicated that health and safety issues were highly regarded by the participants and problems regarding these issues contributed towards their perceptions of doubt in vocational opportunities.

4.2.1.4 Category Four: Doubt in own potential for fulfilment at work

This category emphasizes the doubt that the back injured individual developed in being fulfilled at work. The category is explained by a perception of doubt in return to work strategies and in being accommodated within the workplace. Finally the category highlights the failure of individuals to manage the communication structures of authorities and the consequent doubt of the individual to find meaning in their worker role.

One participant expressed doubt in her ability to be fulfilled at work due to her functional problems after the back injury. She stressed the point that nobody would accept her in her profession due to her problem. She said:

“Ek het so hard probeer om my werk veilig te voltooi maar nog altyd het ek my seer gemaak en net daar het ek begin vrede maak dat nou sal niemand my wil hê in die praktyd met my probleem nie hoekom sal ek nou vir my stress.”

“I tried so hard to safely do my work but I stil managed to hurt myself and it is from this moment that I accepted that nobody will accept me in the practice with my problem, why should I then stress myself.”

Individuals tended to accept that they would not be able to function within the same physical capacity as what they did pre-morbidly thus causing them to become demotivated.

4.2.1.4.1 Doubt in return to work strategies

After rehabilitation procedures the back injured workers were shifted from one position at work to another without taking their feelings and abilities into consideration. They argued that they experienced problems when their job tasks did not suite their abilities. This resulted in them developing feelings of distrust and dissatisfaction towards their job and employers. One participant explained:

“Ek het vantevore nog nooit daai werk gedoen nie, ek het nie daai opleiding nie. Ek voel dat ek gaan my seer maak of nonsense aanvang.”

“I have not done that work before, I don't have that training. I am afraid that I might injure myself or do nonsense.”

The participants felt that decisions about alternative work placement should take the injured employee into consideration. They felt that employers and medical professionals should have discussed future plans with them and that their points of view needed to be heard. As one participant explained:

“Jy moet eers navrae doen of die persoon dit kan doen, hoe voel hy oor die situasie, hy moet eers daar oor dink.”

“You have to first enquire if the person can do it, how he feels about the situation, he has to think about it.”

The evaluation process of health professionals was regarded as important and had great implications on the work status of the back injured individual. One participant felt that assessments that were not specific or client-centered would not take precautions, specific to that individual, into account. This would then greatly affect the participant’s treatment outcome and eventual return to work. She said:

‘Ek sal sê jy moet eers die pasient goed evalueer waartoe is hierdie pasient instaat voor jy met hom begin, van in die proses kan jy miskien vir hom beskadig sy rug of sy knieë van hy is `n arthritis pasient en hy sal beter gedoen het in `n water program. So jy moet saam met die pasient sy program opstel. Maar soos ek gesien het moet almal dieselfde fisio program doen.’

“I will say that you should evaluate the ability of the patient before you begin with him, because in the process you can injure his back or his knees because he might be an arthritis patient and he would have functioned better within a water programme. So you have to set up the programme together with the patient. But what I have seen is that everyone does the same physio programme.”

4.2.1.4.2 Doubt in accommodation within the workplace

The financial budget of companies often determined the availability of jobs for employees. The participants felt that employers used the budget as an excuse not to reasonably accommodate the workers. Employers were often hesitant in providing reasonable accommodation to the injured worker as they felt that they could not be obliged to keep the individual’s salary on the same level. This resulted in the back injured employees having to accept lower paid jobs if they were to be reasonably accommodated. As one participant explained:

“Toe sê hulle vir my dat hulle kan nie vir my skuif in `n ander posisie nie, want hulle is meer geworried ek kry te veel geld.”

“So they told me that they cannot move me to another position because they are worried that I will get too much money.”

The back injured workers felt that supervisors within the work setting tended to ignore the recommendations of health professionals regarding their weaker functional abilities. As one participant explained:

“..op vlakke seniorsvlak, lag hulle as hulle die dokter se goed lees van jou rug. My baas het een keer gelag en gesê dat ek maar `n ander werk moet soek van hulle het nie vrou mens werk nie.”

“...on a seniors level, they laugh if they read the doctors` notes about your back. My boss once laughed and said that I must look for another job as he does not have female work.”

4.2.1.4.3 Doubt in the communication structures of authorities

Feelings of frustration and doubt were expressed by participants at the poor administration services rendered by the Workman’s Compensation organisation. Poor administration procedures resulted in the individuals not being able to process their requests. The participants expressed the need to speak to someone that could advise them on issues such as injury management, however, they tended to be unsuccessful. These poor communication procedures resulted in delays in rehabilitation procedures and consequent poor return to work rates.

“Organisations like the Workman’s Commissioner; surely to God there must be channels that things work. If you don’t get satisfaction here then there is someone else you can go to and say listen I am seeking this avenue but I have come to a stop block. These people must realise that it is our lives that they are dealing with... we can’t wait on the system. We need to heal our selves and return to work.”

Individuals complained that the communication channels at work were not working effectively and often the upper part of the management structure did not know what was happening at lower level structures. This apparent lack of

communication resulted in poor disability management strategies and caused individuals to doubt fulfilment at work. As one participant explained:

“Die onderkant van die leer weet nie wat bo by die leer aangaan nie...van as die werker praat met daai man daar bo dan dan sê daai ou dis nie my besigheid nie.”

“The bottom part of the ladder does not know what is happening at the top part of the ladder because if the worker talks to the man on top then the man replies that it is not his problem.”

4.2.1.4.4 Doubt in finding meaning in the worker role

Absenteeism, as a result of back pain relapses, caused the individual to lose out on opportunities to prove themselves within the workplace and to develop meaning in their worker roles. One participant explained that often, when there was an opportunity to prove to the employer that she was competent at her work, she was absent from work as a result of her back pain. She said:

“..maar elke keer as daar `n uitdagings begin, dan is ek nie daar nie..”



“.. but everytime if there is a challenge, then I am not there..”

The participants felt that employers often disregarded the opinion of health professionals with regard to work-task modifications; they would only respect the opinion of the company doctor. Participants were usually informed by the company doctor that they could return to their duties with the use of tablets. The participants felt that they lost their motivation to continue with their work. This loss of motivation was related to their loss of meaningfulness in doing the work tasks. One participant explained:

“Ok die ander saak is as jou dokter nou jou board, dan stuur die company jou terug na hulle dokter dan maak hy nou weer vir jou fit vir duty met medikasie. Nou die mense gewone mense verloor hulle regte in ons werk. Jy voel dat jy nie terug wil gaan na daai werk nie dit beteken niks vir jou meer nie.”

“ Okay the other situation is when your doctor wants to board you, then the company will send you to their company doctor, then he makes you fit for duty with medication. Now it is the normal person that loses their rights within the workplace. You feel that you don’t want to go back to that job it means nothing to you.”



4.2.2 Theme Two- A team effort: *“Ek is gelukkig in die werk omdat ons almal verstaan die situasie en ondersteun mekaar”*

The theme describes the back injured individuals' experience of a team effort that assisted or aided them in returning to work. The theme will explore injury management mechanisms within the workplace as well as a perception of empathy in the development of relationships between that back injured individual and the relevant stakeholders. Finally the importance of sustaining the back injured individual's basic needs will be viewed as a facilitator in the return to work process.


Participants were of the opinion that they could not maintain their worker role without the assistance of others in the workplace, in the hospital and at home. As one participant said:

“Sonder die span poging van mense by die werk die hospitaal en ons families by die huis so ons baie gesukkel het om terug werk toe te gaan.”



“Without a team effort of people at work, the hospital and our families at home we would have struggled in returning to work.”

Table Three

<p>4.2.2 Theme Two</p> <p>A team effort: “Ek is gelukkig in die werk omdat ons almal verstaan die situasie en ondersteun mekaar.”</p>	
<p>4.2.2.1 Category One</p> <p>Injury management strategies facilitating a team effort</p>	<p>4.2.2.2 Category Two</p> <p>Empathy amongst stakeholders facilitating a team effort</p>
<p>4.2.2.1.1 Regular communication</p> <p>4.2.2.1.2 Holistic management</p> <p>4.2.2.1.3 Ergonomic intervention and accurate employee job placement strategies</p> <p>4.2.2.1.4 Trade union support</p>	<p>4.2.2.2.1 Empathy of employers and co-workers</p>  <p>4.2.2.2.2 Empathy of the medical profession</p> <p>4.2.2.2.3 Empathy of the family</p>

4.2.2.1 Category One: Injury management strategies facilitating a team effort

The category is defined by injury management strategies that aid or facilitate a team effort when returning the injured individual to the workplace. Reference will be made to strategies such as regular communication between the stakeholders and holistic team management. The category will also emphasise work accommodation strategies such as ergonomic intervention, accurate employee job placement and trade union support.

Participants indicated that injury management was important for successful rehabilitation and return to work after the back injury. They frequently referred to a medical team approach, which involved not only the physician or physiotherapist, who deals with the physical problems of the injury, but also the professionals that deal with the psychological problems related to the injury, such as the psychologist or psychiatrist.

“Daar is ’n primêre span waar ’n sielkundige moet inkom daar sal miskien ’n psigiater moet wees. ’n Dokter en ’n fisio moet nie alleen deel van die mediese span wees nie.”

“There is a primary team that must consist of a psychologist and maybe a psychiatrist as well. A doctor and a physio must not be the only people in the medical team.”

The above quote indicated the participant’s view of team work between the stakeholders in rehabilitating and returning the back injured individual to work.

4.2.2.1.1 Regular communication

Regular communication between the employer and the back injured employee was regarded as crucial in ensuring a team effort within the workplace. One participant felt that his employer knew about his medical condition and that this enabled the two of them to have a positive working relationship. He said:

“Soos ek sê um ek werk nou vir iemand anders maar hy my baas ken die situasie. Ek en hy praat gereeld ons verhouding is goed.”

“I am currently working for someone else but he my boss knows the situation. The boss and I talk regularly our relationship is good.”

Regular communication between the employer and the health professional was perceived by the participants as improving their return to work rate.

“Die dokter en my baas praat gereeld oor my kondisie. Toe ek terug werk toe gaan was alles gereel, die tipe werk en al daai goed. So kon ek vinnig weer in die ding in kom.”

“The doctor and my boss talked regularly. When I returned to work everything was arranged, the type of work and all that things. So I could get quickly back into things.”



Communication and interpersonal relationships within the rehabilitation setting were highly regarded by the back injured individual. One participant acknowledged that the positive commitment from the rehabilitation professionals motivated him to successfully complete rehabilitation programmes. At the end of his treatment session the participant felt as if he did not want to leave the treatment center because he enjoyed himself so much. He said:

“..daai twee manne ek dink as hulle mense kan kry wat toegewy is soos daai twee manne hulle job doen...as jy gekom het in die oggende nê vir daai terapie te doen en sê die tyd om is dan wil jy nie loop nie, want dit was baie positief. Ek meen as iemand nou `n probleem het met die oefeninge dan sal hulle jou stap vir stap daar deur vat, al is jy terug by die werk kon jy enige tyd vir hulle bel as jy sukkel met iets.”

“..that two men I think if they can get people that was as motivated as what that two guys were in doing their job...if you arrived in the morning to do the therapy and if the time is up then you do not want to leave, because it was very positive. I

mean if someone had a problem with the exercises then they will take you step by step through the exercises even if you were at work then you could contact them if you had problems with something.”

The above quotes are indicative of a team effort that was portrayed between the participant and stakeholders such as the employer and the medical professional. Without regular communication the participant’s progress within rehabilitation programmes as well as placement within the work setting could not be monitored or improved.

4.2.2.1.2 Holistic management

The management of the participant from the acute stage of the illness to the stage when he/she is ready to return to work facilitated a speedier return to work of the injured. Holistic management within this context referred to a team effort between the participant and the relevant stakeholders (e.g. employer, medical professionals, insurance agency and participant’s family). One participant felt that the employer only acknowledged the severity of his back pain once the occupational therapist explained to the employer about his functional limitations. He said:

“Toe het hulle my deurgeplaas na terapie dit was verlede jaar wat ek hier was toe het my werk begin saam speel.”

“So they referred me to therapy it was last year that I was here, then my work began to comply.”

Some participants interpreted holistic team management as a measure of cost effectiveness as they could save money through the help of their families while doing their home fitness programmes. This assistance facilitated a self-motivating mechanism that in turn allowed individuals to complete rehabilitation programmes safely with minimal financial expenditure on their behalf. One participant said:

“Wat vir my baie gehelp het was my familie wat my deur dit gebring het. Hulle sou my sê jy moet jou oefeninge doen. Ek het my tuis program goed voltooi met die help van my familie sonder om geld te spandeer aan terapie.

“What helped me was my family. They would remind me to complete my exercises. I have completed my home program quit well with the help of my family without spending money on therapy.”

4.2.2.1.3 Ergonomic intervention and accurate employee job placement strategies

Participants felt that workplace accommodations aided them in being productive within the workplace. One participant explained that she was given a chair with wheels that replaced her old heavy chair that made mobility around the office easier. In this way her job routine was made easier due to environmental adaptation. She said:

“Hulle het my daarom `n stoel gegee wat wieletjies het... dit het my baie gehelp omdat ek moet heen en weer beweeg tussen die liaseer cabinet en die kleine plekke op die lessenaar.”

“They at least gave me a chair that had wheels... it helped me a great deal because I had to move around between the cabinet and the small areas by the desk.”

Restructuring of the work environment was described as a method of injury management in adjusting the individual to their specific work tasks. This readjustment caused individuals to work in a safer ergonomically designed work environment. One participant described how rehabilitation professionals assisted her after her injury in restructuring her work environment in order to make her work tasks easier. She said:

“Hulle het spesiaal die hele area wat ek in die werk het om geskep en alles was nou hoog en hulle het mense laat kom van Groote Schuur.”

“They specially redesigned the entire area where I worked and everything was now high and they had people come from Groote Schuur.”

Sometimes the employee's job description could not be changed entirely, however, there were always accommodations that could make the back injured employee more comfortable in the workplace. As one participant said:

“Ek sal sê om my werk ligter te maak nou miskien as daar `n drywer kort is hulle stuur my uit dan moet iemand anders saam met my uit gaan.”

“I will say to make my job easier maybe if there is a driver short, then they will send me out. They would then send someone else with me.”

The above quotation explained how a truck driver was given an assistant during his routine tasks in order to ease his job load. Workplace accommodations need not be expensive to the company and it could mean a simple restructuring of daily routines.

One participant explained that after her injury her employer accommodated her in the workplace by changing her job description from working with patients to an administrative type of occupation. She said:

“Toe vra hulle as ek nie by opleiding wil gaan werk nie, `n hele klomp jare wat ek nie met pasiente werk nie tensy nou daar skielik nou `n noodgeval is.”

“So they asked if I don't want to work at training, it's been years that I have not been working with patients besides if there is an emergency.”

The participants' experience and knowledge concerning their work were seen as valuable, particularly when they had to be placed in an alternative job. One participant said:

“My rug lol `n bietjie, want slegs my teenwoordigheid maak baie saak, dan hoef ek nie om te werk nie, maar dan moet ek sien dat hulle die werk reg doen.”

“My back is bothering me, but only my participation is important, then I don't need to work, I have to only see that they are doing the work correctly.”

Participants who had a good understanding of their work were accommodated in a supervisory role. This, therefore, prevented them from doing physically exhausting tasks that usually aggravated their back pain. However, without the support or team effort of the employer and co-workers, reasonable accommodation within the workplace would not be possible.

4.2.2.1.4 Trade union support

Trade unions within the workplace often supported employers and injured employees to follow legitimate channels during work disputes. Their support often facilitated a team effort between the employers and employees during the return to work process. Participants expressed the view that they were confident in not losing their jobs after their injury when managers and shopstewards supported them by explaining, step by step, work policies to them.

“In the workplace the main concern is the injured workers awareness of policies that aid him in the workplace. Management and shop stewards aided us and explained how these policies protect us.”



The union official played a pivotal role within the work atmosphere. Their role was to ensure that the worker was working within a safe environment and that all work policies ensured that employees are treated fairly. Individuals felt that the unions within the workplace facilitated teamwork with the medical sector and the employer through regular communication. As one participant explained:

“Ek is weer first name terms, ek gaan nie gevriet koop by jou nie. Ek gaan vir jou druk. Ek is hier om te sien dat die werk gedoen word dat jy die werk doen maar ek is terselfde tyd om te sien dat die werker fair en lekker hanteer word. Ek het gesien dat die werker sy regte ken en dat die dokter en die bestuurder saam moet werk.”

“I (shopsteward) am on first name terms I do not expect to be favoured by you. I'm going to be firm. I am here to see that the work is complete and also to see that the worker is treated fairly. I saw to it that the worker was aware of his rights and that the doctor and the manager worked together.”

The above quotes are indicative of the participant's perception of a team effort in returning the back injured individual to work.

4.2.2.2 Category Two: Empathy amongst stakeholders facilitating a team effort

This category highlights the importance of the stakeholders having empathy for the back injured individual. Empathy in this context is explained by the understanding relationships between the back injured individual and the stakeholders (e.g. employer, medical professional and the family). Stakeholders that conveyed empathy and support for the back injured individual reinforced teamwork or a team effort in the return to work process.

Co-workers who had empathy for participants facilitated a positive working culture. One participant was impressed by the fact that although her co-workers had known about her back condition they continued to praise her efforts when she initiated work tasks. If a problem occurred within the workplace then the staff would work together as a team until the problem was resolved. This was seen as a motivating factor for her to improve herself and to work harder in recovering from the injury. She said:

“Jy kry prys ten spyte van jou probleme. As daar `n probleem is dan werk ons almal te saam. Dit motiveer jou om hard te werk aan jou rug probleem.”

“You get praised despite the problems that you have. If there is a problem then all of us would work together. It motivates you to work hard to recover from your back problem.”

4.2.2.2.1 Empathy of employers and co-workers

Supervisors who had an empathetic understanding of the back injured individual's condition often allowed them to complete tasks that would not cause them back pain. As one participant said:

“..en uh nou sê sy (baas) altyd laat die ou mense net nie so baie werk nie.”

“..and uh now she (boss) always says that just don’t let the old people work too hard.”

Managers who advocated on behalf of the back injured workers fostered a comfortable working environment for the injured. As the managers were informed about the individuals’ limitations, feelings of fear and shame were reduced amongst the back injured workers. This process enabled the participants to continue with their daily work routines with the help and co-operation of co-workers. As one participant said:

“Meneer, staan jy daar jy moenie worry nie ek weet van jou rug probleem ons sal vir jou help om dit af te laai.”

“Sir, stand over there you must not worry I know about your back problem we will help you deliver it.”

Positive relationships within the workplace were regarded as very important, the participants acknowledged how much they appreciated it when co-workers empathised with them. One participant said:

“Daar is mense wat party keer regtig waar daarop is om sê maar tee tyd gou vir jou te-vra hoe gaan dit. Somtyds kom die baas en van die werkers om vir my `n grap te vertel ek dink hulle probeer hard om jou te verstaan.”

“There are people that sometimes acknowledge you during tea time by asking you how you are doing. Sometimes the boss and some of the workers come to me to tell me a joke I think that they try hard to understand you.”

Financial limitations during or after the rehabilitation process were regarded as problematic for the back injured worker in adjusting to their pre-morbid role. One participant explained that her employer showed her empathy by providing her with a micro loan in order to repay her debts. The participant viewed this financial support of her employer as facilitatory in her attempt to return to work. She said:

“Daar was tye van die ses maande nou, was daar mos nou niks nie, skuld staan stil alles staan stil. Toe gaan ek na hom toe, toe sê ek ek voel ek gaan `n lening maak vir ses maande. Joshua Door het vir my `n bed gebring en die firma het dit betaal.”

“There was times during the six months, that there were no finances, your debts are accumulating. Therefore I went to him, so I told him that I feel that I am going to make a loan. Joshua Door brought me my bed and the firm paid for it.”

The above quotes express the perception of empathy that employers and co-workers had for the participant's back pain. This encouraged the participants to feel accepted within the work setting hence reinforcing the concept of a team effort.

4.2.2.2.2 Empathy of the medical profession

Participants were of the perception that medical professionals who showed empathy towards their back condition facilitated their recovery and successful return to work. They felt that medical professionals who explained their back problems to the employer and family often facilitated a team effort amongst the stakeholders. One participant said:

“Some doctors or therapists try to understand you and your back problem. It is those people that would speak to your employer and your family. They ensure that you could go on with life.”

4.2.2.2.3 Empathy of the family

The support and empathy of families for the back injured individual during and after rehabilitation programmes were seen as imperative in the return to work process. One participant stated that he could not go to work in the morning without the support and assistance of his wife.

“Nou vroeg oggende as ek nou opgestaan het, voor ek werk toe gaan en ek kom nou uit daai badkamer uit dan moet ek eers sê vir my vrou kom smeer nou eers `n bietjie man, sonder haar help weet ek nie wat ek sou gedoen het nie.”

“now early in the morning when I got up from bed before I went to work and im coming out of the bathroom, then I must ask my wife to rub my back, without her support I don ’t know what I would have done.”

Another participant mentioned that her husband often had to put a cushion in their car before they drove so that her back pain was relieved. This form of family support was seen as essential in reinforcing a team effort between the back injured individual and their family. The team effort facilitated the adaptation and acceptance of the back injured individual’s condition. She said:

“soos my man as ons gaan kar ry moet hy vir my ’n kussing in sit..”

“like my husband when we are going driving then he has to put a pillow on the back of my seat..”

The participants in the study felt that their families contributed to the success of them returning to work. Without the team effort of the individual and his/her family the process of returning to work would have been extremely difficult.

4.2.3 Theme Three- Responsibility for self: “*Ek moet agter my self kyk...*”

The theme explains how the back injured individuals adapted to their worker role after their injury by taking responsibility for themselves. This responsibility caused back injured individuals to develop a positive self-image and motivated them to complete rehabilitation programmes. As one participant said:


“Ek is erens anders besig want ek moet agter myself kyk, anderste beland ek weer in die hospitaal.”

“I am busy somewhere else because I have to look after myself, otherwise I’ll end up in the hospital.”

The participants’ perceptions of taking responsibility for self in order to accomplish personal goals will be explored. There will be an emphasis on the importance of taking control of oneself, achieving worker role competency as well as being aware of and utilising medical services.



Table Four

4.2.3 Theme Three- Responsibility for self: “Ek moet agter my self kyk..”		
4.2.3.1 Category One Taking control of yourself	4.2.3.2 Category Two Developing competency in your worker role	4.2.3.3 Category Three Being aware of and utilising your own choice of intervention
4.2.3.1.1 Reorganisation of yourself	4.2.3.2.1 Education and training of the worker	4.2.3.3.1 Being aware of and utilising biomechanical intervention
4.2.3.1.2 Developing a positive attitude and accepting your medical condition	4.2.3.2.2 Assertion of yourself	4.2.3.3.2 Being aware of and utilising ergonomics & energy conservation
4.2.3.1.3 Exercising your legal rights within the workplace	4.2.3.2.3 Having multiple work skills 	4.2.3.3.3 Being aware of and utilising surgical intervention
	4.2.3.2.4 Creating your own meaning and satisfaction in tasks	4.2.3.3.4 Being aware of and utilising pharmaceutical intervention
		4.2.3.3.5 Being aware of and utilising psychotherapeutic intervention

4.2.3.1 Category One: Taking control of yourself

The category is characterised by the back injured individual's ability to take control of his/her life. It is explained by reorganising one's self, having a positive attitude and acceptance of the back injury. Finally an emphasis is made on the back injured individual's ability to exercise his/her legal rights within the workplace. The theme taking control of yourself is indicative of the individual's ability to master the challenges they faced after the back injury. If they mastered the challenges then feelings of self-efficacy were reinforced.

Administrative problems often developed within organisations like Workman's Compensation and this resulted in great frustration particularly with the back injured workers. Participants became frustrated with the system as their reports were repeatedly lost or no records were made available to them. These individuals decided to take control of their own administrative procedures by compiling their own medical files and reports. As one participant said:

“Soos die mense wat daar mee werk weet nie wat hulle doen nie. Voltooi ek dit, my mense het dit geteken toe faks ek dit vir hulle terug, ja ek sit met my eie lêer wat ek mee besig is.”

“So the people who work with it do not know what they are doing. I complete it, my people signed it thereafter I faxed it back to them, yes I have my own file that I'm busy with.”

4.2.3.1.1 Reorganisation of yourself

Participants felt that they had to reorganise themselves in order to resume their pre morbid functional status. One participant said that he had to positively reorganise his lifestyle and follow the instructions from the rehabilitation professionals in order to do activities such as playing football and cycling. He expressed the view that people had the tendency to remind themselves of the negative aspects of the back injury. He said:

“En ek glo in my geval ek as ek positief is en jy doen wat die mense sê jy moet doen glo ek met my hele hart ek kan alles weer doen ek kan weer sokker speel. Toe

sê ek vir my self ek gaan hierdie jaar `n tyd op stel, as jy `n rugprobleem ontwikkel het nê dan wil jy altyd jouself remind ek kan nou nie daai doen nie omdat my rug seer is, en ek het op my bike geklim en ge-oefen in Stellenbosch.”

“And I believe in my circumstances if you are positive and you do what the people say you must do I believe with my heart that I can do everything again, I can play soccer again. So I told myself that I am going to set up a time because if you have developed a back problem then you tend to remind yourself that you cannot do that because your back is painful, and I got onto my bike and I began to practise in Stellenbosch.”

Participants were of the opinion that it was important to to have self-discipline and motivate themselves. They felt that they had to do the muscular strengthening exercises the prescribed way. The participant said:

“..en soos die tyd aan gegaan het, het ek die regte oefeninge gedoen wat hulle gesê het by die huis en somtyds dan vergeet ek maar dan motiveer ek myself om die volgende dag te oefen.”



“ ..and as the time passed so did I do the correct exercises that they said I should do at home and sometimes I forgot but then I would motivate myself to exercise the following day.”

4.2.3.1.2 Developing a positive attitude and accepting your medical condition

Participants expressed the view that when you are positive and you are consistent in your rehabilitation programmes then you will be successful in returning to work. As one participant said:

“Ek glo regtig as `n mens positief is en die regte ding doen en jy wil regkom en en jy hoor as iemand jou leer wat al klaar daai experience het, en ek glo, en ek doen my werk.”

“I believe if a person is positive and you do the right thing and you want to recover and you listen to someone with that experience or who wants to educate you about your condition and you believe and do your work.”

The back injured workers felt that they should not take it for granted that others will always be there to help them in the rehabilitation process, however, they had to depend on themselves or their medical condition would deteriorate. One participant said:

“Is dat jy vat nie net vir granted dat die een en daai een moet vir jou help nie want as jy gaan depend op ander mense dan gaan jy nooit jousef help nie.”

“It is that you are not taking for granted that this one and that one must help you because if you are going to depend on others then you are never going to help yourself.”

Participants emphasized that an individual must be able to show the employer that they can do their work without any complaints of having pain. The workers felt that in this way they would not be discriminated against. As the participant said:

“Om te kan bewys jy kan daai werk doen. Jy moet daai persoon wys jy het nie pyn nie.”

“To prove that you can do the work. You must show the person that you do not have pain.”

According to one participant he could only deal with the medical and financial aspects of his condition by persevering and not giving up hope. This attitude of perseverance therefore served as a method of adapting within an unresponsive environment. He said:

“..ek het my werk verloor so wat gaan ek dan nou doen. Ek het aangehou aangehou tot na die nurse my gestuur het na Ancie toe, toe vul sy in die vorms vir arbeidsterapie.”

“..I have lost my work so what must I do. I persevered until the nurse sent me to Ancie, so she filled in the forms for occupational therapy.”

Pain was a problem that most back injured individuals had to endure everyday. Participants felt that they had to accept the pain and live with it. One participant said:

“Jy moet maar lewe saam met die pyn, jy moet jou opbeur om vir jou dinge, dis moeilik dis pyn.”

“You have to live with the pain, you must uplift yourself to do things, it is difficult because of the pain.”

4.2.3.1.3 Exercising your legal rights within the workplace

Participants viewed the Employment Equity Act as an act that was put in place to eliminate the discrimination against women and previously disadvantaged race groups within the workplace. Participants felt that the change in the political system assisted the back injured workers in adapting to their worker roles.

One participant said:

“Because the underprivileged people had to become privileged uh with employment equity, the gender, women being involved in the industry..”

Participants felt that more workers were becoming aware of their rights within the workplace as well as exercising their rights through unions. They felt that they could maintain their worker roles because they were informed about health and safety regulations of the workplace. The exercising of their rights was seen as a way in which the back injured could assert themselves. This ensured that they were treated fairly and not unfairly dismissed because of their injury. One participant said:

“...it is starting in the workplace today that workers are more geared up with the different forums in the companies and with the unions coming in...”

4.2.3.2 Category Two: Developing competency in your worker role

The category explains the back injured individuals' perceptions of educating and training themselves when returning to work. Reference is also made to the role of assertiveness when solving problems within the workplace, having multiple skills and the creation of meaning/satisfaction in work tasks.

Participants were of the perception that in order to be successful at work they had to be competent in all their work tasks. This enabled them to adapt to the work situation after the injury. One participant said:

“Ek voel dat ek kon maklik in die werk in pas omdat ek my werk so goed ken. Die bestuurder het geweet dat ek `n goeie werker is en dat hy nie vir my wil verloor nie.”

“I think that I could adapt well within the work environment because I know my work well. The manager knew that I was a good worker and that he didn't want to loose me.”



4.2.3.2.1 Education and training of the worker

Continued education and training of workers positively influenced health and safety standards within the workplace. One participant explained that he (union official) made sure that the other workers in his sector received education with regards to work safety policy, and that this contributed to less workplace injuries. Education and training of the back injured employee within the workplace was therefore seen as one method of adapting to the worker role. As one participant said:

“Maak die mense bewus en nou weet ek (unie beampte) hulle het nie `n eskuus nie en so het ons gemaak. Ons het altyd vir die bestuurder gesê dat as hy die safety training elke jaar doen sal daar minder beserings wees.”

“Make the people aware and now I (union official) know that they do not have an excuse and so we proceeded. We always told the manager that if he does the safety training once a year then he will have less injuries”

The thorough training of the injured worker within the workplace was regarded as important for worker role competency. The injured workers expressed the view that it was the employer's duty to give clear verbal or written instructions to them in order to avoid errors and for them to feel safe in the workplace. In this way back injuries would be prevented within the workplace. The participant said:

“Hy is `n bleddie fool dis jou plig om daai persoon tou wys te maak jy weet. Jy sê kyk jy moet dit doen jy moet daai doen jy moet dit so doen van jy weet hoe jy dit wil hê. Die beseerde of die nuwe werker moet nie verwag word om automaties te weet wat jy wil he nie.”

“He is a fool, it is your duty to make that person aware you know. You say look here you don't do it that way you do it this way because you know how you want it. The injured or the new worker must not be expected to automatically know what you want.”

4.2.3.2 Assertion of yourself



To be assertive while solving a problematic situation was seen as a method of avoiding reinjury and being competent in your worker role. One participant felt that he had to assert himself by acting swiftly in order to prevent conflict with his employer. He said:

“Daar is tye wat jy weet jy kan dit nie optel nie maar omdat hy die baas is wil hy hê jy moet...maar as ek gevoel het sal ek hom sê ek kan nie, dan raak die ou somtyds kwaad dan het ek nie moet om te gaan agter die ou nie somtyds voor die werkers nie, dan sal ek dit address op `n goeie manier dan sê ek ek kan dit nie optel nie, sal jy my iemand gee om vir my te help.”

“There are times that you know that you cannot lift an object then your boss forces you to but I will tell him that I can't and then he sometimes becomes angry. I have decided to approach him when there isn't any other workers, then I will address him in a good manner, I'll explain to him that I can't lift it, can he perhaps give me someone to help me.”

4.2.3.2.3 Having multiple work skills

Multiple work skills enabled the back injured workers to do alternate work as a result of limited funds after their back injuries. This enabled them to take control of their back pain by participating in work tasks that placed minimal strain on their spines as well as to earn an extra income. One participant said:

“Van ek het so `n trok wat ek naweke vervoer mee doen dan het ek die mense wat my help, maar ek is self binne in die trok en vat aan en help skuif die goed.”

“Because I have a truck that I do transportation with on the weekend then I have people that help me, but I am inside the truck and assist and help shift goods.”

Participants attributed their competency at work to their ability to do a variety of work tasks. They felt that this provided them with independence and enabled them to prove to their supervisors that they could do alternative tasks within the workplace. As one participant said:



“I am lucky that I could do virtually everything at work. So when I got injured I could work in whatever section I wanted without any hassles from the supervisor.”

4.2.3.2.4 Creating your own meaning and satisfaction in work tasks

The value and meaning that the back injured workers placed on their work influenced their motivation to return to work. The participants felt that they enjoyed their work because they felt competent in doing the work.

One participant said:

“Ja kyk as jy lief is vir jou werk jy bly nie somer uit nie. Want jy het die werk geleer nou leer jy nog ander manne ook.”

“Yes, if you like your work you don’t just stay absent from work. Because you have learned the tasks of the job, now you can educate other people as well.”

One participant felt that he had a responsibility towards his employer because he was the one that was dependent on the employer for the work. He felt that he

enjoyed getting up early in the morning because he had a job to go to. This feeling of satisfaction allowed him to continue within his worker role despite the pain that he was experiencing. He said:

“Ek het geklop daar om te kom werk soek en dit is nog altyd wat vir my laat opstaan al moet ek 5 uur opstaan in die oggend ek moet na my werk toe gaan want ek het `n werk en dit is wat my laat goed voel.”

“I knocked there to look for work and it has always been this perception that motivated me get up from bed at 5 o`clock in the morning, I have to go to my work because I have a job and this is what makes me feel good.”

Seniority in the workplace enabled participants to gain respect from colleagues as well as enabled them to feel valued. This respect was internalised by the participant as it was giving him meaning with regards to his worker role.

The participant said:



“...maar omdat ek `n senior geklas word onder hulle, omdat ek part is van die office dat ek dit so stel, sien hulle vir my as `n senior van hulle en uh is nie dat hulle snaaks is teenoor my nie.”

“...but because I was regarded as a senior by them, and because I was part of the office let me put it to you like this, they see me as a senior because and ah they are not nasty with me.”

The above quotes indicated that the participants developed competency in their work by experiencing meaning and satisfaction in their worker role.

4.2.3.3 Category Three: Being aware of and utilising your own choice of intervention

The category explains the back injured individual's use of treatment modalities. Reference will be made to rehabilitation modalities such as biomechanics, ergonomics and job placement strategies. There will also be emphasis on medical

modalities such as surgical intervention, pharmaceutical intervention and psychotherapeutic intervention.

One participant explained that he educated himself by reading articles that focused on the services of chiropractors. This knowledge of alternative therapies assisted the back injured workers to have a choice in treatment modalities when remediating their back injuries. Individuals felt that the awareness of treatment modalities enabled them to take control of their lives by choosing modalities according to their health needs. He said:

“Ek het iets gaan leer van `n chiropracter. Dat hy konsentreer net op jou ruggraat en so word jy gesond in ander parte van jou liggaam want jy gebruik nie pille nie.”

“I went to learn about the services of a chiropractor. That he concentrates only on your spine and this is how you get healthy in other parts of your body because you do not use tablets.”



The above quote indicated the participant's knowledge of treatment modalities that were conducive to their health. Individuals developed a perception of control over medical and rehabilitation procedures if they were aware of the consequent benefits and risks involved.

4.2.3.3.1 Being aware of and utilising biomechanical interventions

Participants felt that their back conditions improved with the use of fitness programmes that they received from the physiotherapist and the occupational therapist. The importance of being consistent in executing home treatment programmes was seen as crucial for successful rehabilitation. Once individuals performed the fitness programmes at home they could return to work without any stress of being unfit for duty. As one participant said:

“Toe ek van Libertas Hospitaal af gaan toe het hulle vir my `n program gegee, `n fitness program wat ek kan sê tot vandag toe nog volg.”

“When I finished my programme at Libertas Hospital, so they gave me a programme, a fitness programme, that I can say that I follow up to today.”

4.2.3.3.2 Being aware of and utilising ergonomics and energy conservation

Conserving energy has been seen as fundamental in completing work tasks. One participant mentioned that he had extended his broom that he used to sweep the floors at work in order to make his sweeping task easier. He said:

“As ek vee toe het ek my besem stok langer gemaak ander woorde ek kan regop vee..”

“Because I had to sweep, I made my broom stick longer in other words I can sweep with my body upright..”

The back injured workers expressed their view of planning their work routines more effectively in order to conserve energy. One participant explained that simple tasks such, as bathing herself was time consuming. She adapted by getting up earlier than usual in the morning in order to bath herself, this allowed her ample time to attend early hospital appointments. She said:

“Ja in ander woorde ek het goeters goed beplan wat ek gaan doen vandag. Ek weet dat nou na my ongeluk vat ek baie lang om te beweeg en om take te voltooi. Daai is hoekom ek vanoggend baie vroeg opgestaan het dat ek hier kan wees, dan vat dit nie so baie krag uit my nie”

“Yes in other words I planned my things for the day quite well. I know that after the injury I have been taking longer to complete tasks. That is why I stood up quite early this morning in order to be here, so I don't become drained of my energy.”

Another participant replied that she had a small foot stool that she made use of in order to reach articles above shoulder height. This prevented her from injuring herself in the future. She said:

“Ek het `n lekker bankie wat ek opstaan by die huis om `n ding vir my af te haal.”

“I have a nice foot stool that I use to stand on at home in order to take down something.”

4.2.3.3.3 Being aware of and utilising surgical intervention

Some anatomical causes of radiating back pain were due to nerves that were impinged by bone. Surgical procedures were essential in correcting this abnormality as no other rehabilitation modality would be able to correct the lesion.

As one participant explained:

“Die pyn is veroorsaak deur senuwees, dis senuwees daarom het ek dat hulle vir my opereer het. Dit is senuwees wat vas druk, dit was noodsaaklik dat ek vir die operasie gaan. Nou voel ek beter.”

“The pain is caused through nerves, it is nerves that is why I allowed them to operate on me. It is nerves that are impinged, it was essential that I went for the operation. Now I feel beter.”



4.2.3.3.4 Being aware of and utilising pharmaceutical intervention

The use of medication for temporary pain relief developed into a dependency on pain medication for the back injured individuals. The participants felt that they had no other choice in relieving pain if they wanted to continue to live productive lives. As one participant said:

“Ons gebruik verskillende pille, ek gebruik bevoorbeeld 5 pille wat ek moet elke dag gebruik..hy verlig die pyn.. Want jy moet anti inflamatoriese goeters drink om te kan half die inflamasië te kan verlig. Somtyds veroorsaak die pynpil soveel spierspasma dat jy spierverslappers moet drink. En dan kom jy by die anti depressante waar sonder jy nooit kan wees nie.”

“We use different tablets, I use for example five different tablets everyday..it relieves the pain. Because you must take anti- inflammatory things in order to relieve the inflammation. Sometimes the pain tablet causes so much muscular spasm that you must drink muscle relaxants. Then you come to the anti depressants where without you can never be.”

The above quote indicated that individuals were compelled to use longterm pharmaceutical interventions that often had severe side-effects as they were not aware of alternative treatment modalities.

4.2.3.3.5 Being aware of and utilising psychotherapeutic intervention

Most back injured individuals were of the perception that only tablets could relieve their pain. When they became aware of other modalities such as psychotherapy then their dependency on tablets lessened. Psychotherapeutic intervention has been used as a measure of relieving and controlling pain. The psychotherapeutic management of the back condition was viewed as essential in adapting to rehabilitation programmes and to the back injured individual’s new life roles. One participant felt relieved of her back pain after she had undergone therapy with a psychologist. As one participant said:

“Toe op `n stadium kom ek by `n fantastiese sielkunde wat vir my gesê het ek het nog nooit gerou oor my rug nie, wat nie meer daar is nie, dit is soos `n familie lid wat jy verloor het.”

“So at a stage I came across a fantastic psychologist, he told me that I have not grieved about my back, that is not there anymore, it is like a family member that you have lost.”

4.2.4 Theme Four- Moving towards an ideal programme: “Nou wat soorte program sal my werk en gesondheid bly hou?”

The theme explains the back injured individuals' interest in treatment programmes that will return them to work and maintain their health. Participants felt despondent about the current rehabilitation system. They developed the perception that treatment programmes were not detailed enough to successfully rehabilitate and return them to work. Participants felt that treatment programmes lacked an approach that incorporated their families, insurance companies and work.

The categories that follow discuss the participants' perceptions of the importance of having informed stakeholders with regard to their back condition. Finally work promotion strategies and transparent stakeholder policies will be discussed with an emphasis on a healthy environment in the workplace.

Informed and transparent stakeholders (e.g. employer, medical professional and family) enabled the participants to accept his/her medical condition by supporting and developing an environment that was conducive to the participants' health and reduced functional ability. As the back injured individual regained his/her strength, their adaptation within the work environment improved. This ultimately caused individuals to develop confidence in their worker roles.

Table 5

4.2.4 Theme Four- Moving towards an ideal programme: <i>“Nou wat soorte program sal my werk en gesondheid bly hou?”</i>			
4.2.4.1 Category One Informed stakeholders	4.2.4.2 Category Two Work promotion strategies	4.2.4.3 Category Three Stakeholder transparency to aid programme development	4.2.4.4 Category Four Healthy work environments
4.2.4.1.1 Informed employers 4.2.4.1.2 Informed practitioners 4.2.4.1.3 Informed family members	4.2.4.2.1 Multi skilled health professionals 4.2.4.2.2 Injury and disability assessment teams 4.2.4.2.3 Work test placement 4.2.4.2.4 In house training courses 4.2.4.2.5 Supported employment 4.2.4.2.6 Skilled job placement strategies	4.2.4.3.1 Employer and physician transparency regarding the individual’s back condition	

4.2.4.1 Category One: Informed stakeholders

The category explains the importance of disseminating knowledge about the prevention and treatment of back injuries to all stakeholders. The stakeholders in this context consisted of the employer, the medical professional and the family of the injured.

The participants were of the opinion that workplace seminars could be utilised as a measure to educate workers and managers on injury management strategies. Participants felt that workers and managers would get a better understanding of injury prevention if the seminars were to be given by someone that has experience with regard to the legal and administrative processes of injury management. As one participant said:

“Dan sê hy luister man kan ons van julle metodis gebruik ons wil hê jy met die rug probleem moet vir ander `n lesing gee oor risiko beheer in die werks plek, hoe jy dit doen en maak.”



“Then he says listen man can't we use some of your methods, we want you with the back problem to give others a lecture on risk management in die workplace, how you do it and make it.”

Empowering the workers with knowledge on health and safety issues was seen as a method of preventing injury as well as in allowing individuals to maintain their health within the workplace. One participant felt that dissemination of knowledge from the top structure within the workplace was questionable as not all workers were informed about workplace policies and procedures. He said:

“..uh dissemination of information from above comes down, certain places it hooks but it has to get through to all the people. If this information had to come through then a whole lot of people will still be their work today.”

4.2.4.1.1 Informed employers

There was a strong emphasis by participants that managers should be informed of their back condition and about management strategies that could improve their

conditions at work. They mentioned that there was nobody on a management level that understood them and that was prepared to make decisions in collaboration with them. As one participant said:

“So van my kant af sal ek nou net kan sê dit sal goed wees as van die base of direkteure of die mense op die hoe vlak bietjie meer inligting kry aangaande hoe ons probleem is. Ek dink nie daar is `n man wat hoor wat jy sê nie, die uitvoer van die ding is nie daar nie en dit maak ons mense baie negatief.”

So from my side, I would just like to say that it would have been nice if bosses or directors on a high level become more informed about our problems. I don't think that there is a person that listens to what we have to say, the completion of the thing is not there and this makes our people very negative.”

Participants explained what an instrumental role management could play within the lives of the back injured workers. They felt that if management were better informed about their functional limitations then they could manage the injured in a supportive manner, which would improve the morale in the workplace. This would create awareness with regard to the dangers that caused the individual's injury as well as creating better support for the rehabilitation processes involved. He said:

“Basies die werk moet die mense meer in lug omtrend hulle probleem. Hoe hulle vir mense kan help om te kan rehab om ander gedagte te kry om meer self vertrou te kry en weer positief te wees en om die werkgewers te benader sodat hulle kan sien wat die mense wat seer kry wat hulle moet deurmaak. Dat hulle ook meer ingelig kan word van hoe jy voel en wat maak jou dag.”

“Basically the work has to educate people with regard to their problem. How they can help people to rehab in order to get a different mind- set, to become more self confident and to be more positive and to approach people so that they can see what processes the individual had to undergo if they get hurt. So that they can get more insight into how you feel and what makes your day.”

4.2.4.1.2 Informed practitioners

Health professionals who were in charge of rehabilitation programmes had to specifically educate themselves by constantly updating their knowledge of the back injured individual's pathology and etiology. The participants had the perception that medical professionals who were not well informed and did not adequately assess the client's back condition could endanger their client's life.

As one participant said:

“Jou maag is seer en die valium het die depressie begin, blykbaar het die depressie daar begin en ek het dit nie geweet nie. En toe was ek nou baie lank by fisioterapeut en op daardie medikasie en toe gee my lewer in as gevolg van al die medikasie.”

“Your stomach is painful and the valium started the depression, apparently the depression had started there and I did not know this. And I was for quite sometime by the physiotherapist and on that medication and so my liver's functioning deteriorated as a result of all the medication.”



The accurate assessment of the patient's medical condition formed the foundation for the successful outcomes in the back injured individuals' rehabilitation programmes. The participants felt that if a patient's condition was thoroughly assessed and evaluated then avoidable complications could be prevented. As one participant said:

“Mense moet definitief goed evalueer word om te kyk hoe kan ek sulke probleme voor kom.”

“People must be definitely evaluated well, to see how I can eliminate this type of problem.”

4.2.4.1.3 Informed family members

Participants felt that their family members were of importance particularly during the rehabilitation and return to work period after the injury. Individuals felt that family members needed to know everything pertaining to the back condition, as

they had to assist the participants with their back pain. The participants felt that family members needed to know about adaptations in the home and what precautions to take when handling them. One participant said:

“I don’t want my wife to become burdened by me. I know that we can’t do the same things that we did before. Therefore I feel that someone be it the doctor or physio needs to tell them what I can do and what I can’t do. This way we could help each other.”

4.2.4.2 Category Two: Work promotion strategies

The category explains strategies that will enable back injured individuals to maintain employment after their injuries. There will be an emphasis on multi skilled health professionals, injury/disability assessment teams, work test placement and in-house training. The importance of supported employment and skilled job placement strategies will also be highlighted.

One participant mentioned that employers could save money in limiting unnecessary medical retirement payouts by creating alternative jobs within the workplace for the back injured individual. This could be achieved by training the back injured workers for jobs of employees that are in the process of retiring from their jobs. This strategy could save employers from employing a new poorly experienced worker. As one participant said:

“...nou phase hulle vir jou in, hulle gooi jou nie in die diep end nie hulle sit jou ook daar by iemand wat amper op retirement pad is, die ou se kennis kan hy alles vir jou gee. So beteken jy iets vir die maatskappy. ”

“..now they are phasing you in, they do not throw you in the deep end, they place you with someone that is about to be retired, his experience he can give you. So you mean something to the company.”

4.2.4.2.1 Multi skilled health professionals

Complications within the workplace often resulted when the medical practitioner could not provide an explanation of the patient’s functional capacity after the back

injury. The back injured workers felt that the physician should be trained to assess the patient holistically not only in terms of their medical problems but also their functional status within the workplace. If the physician has difficulty in assessing the client's functional capacity then a referral to a health professional such as an occupational therapist or physiotherapist would be recommended. One participant said:

“You are working in a different capacity now because you are injured even though I did mention it before that the doctor does write it in his final medical report back to normal duty but he forgets to add in a different capacity.”

“I feel that if the doctor struggles in doing his job because of his load then he should refer to someone like the therapist that could assist him.”

4.2.4.2.2 Injury and disability assessment teams

The participants felt that decisions regarding the future of back injured individuals had to be made in consultation with other stakeholders such as the medical practitioner and occupational therapist from the health sector, and the human and labour relations departments from the business sector. One participant said:

“If you get brought in front of a board like I was sent for occupational therapy here. If on this board you have Human Resource people and Labour Relations people you have an occupational therapist, you have all the different people on this board and you as a worker that has been hurt appears in front of the board and the board will decide about your work fitness.”

4.2.4.2.3 Work test placement

Work test placement was seen as a method of exploring the back injured workers skill in doing alternative work. If the individual meets the requirements for the specific job then permanency for the work position must be considered. As the participant said:

“You've got twelve years experience in the shop so we can like give this guy a three month trial on this. To put him on a probation for six months on this specific

job, that we want to now get somebody to do and if you meet the requirement after three months and the oke (man) is up to standard give him the position because his years of service covers the matric.”

4.2.4.2.4 Inhouse training

Training within the company doing alternative work was viewed as a method of preventing back injured individuals from losing their jobs. In this way the company would benefit from a loyal worker who would remain productive to the company. One participant said:

“Uh why don’t the company send me for training that I can mean something that I can be going to the administrative side. I can become a wage clerk I can become a invoicing clerk”

4.2.4.2.5 Supported employment

Financial support from the employer was seen as essential for the basic survival needs of the back injured worker especially while they were undergoing rehabilitation. One participant felt that all that was needed was for someone to create employment opportunities for the unemployed or unskilled back injured individual. These opportunities were viewed in the form of a temporary disability grant that would assist the participant with living expenses while seeking employment or attending training courses. He said:

“Getting a temporary disability grant I’m quite prepared to work if you can give me the job to do it, If you can take the responsibility someone just take the responsibility and say listen lets just give this dog a chance.”

The participants were of the opinion that if an employment opportunity materialised then they would not need the disability grant. One participant said:

“Kyk ons wil nie verniet geld hê laat ons ook `n werkie doen dan nou deur Tygerberg. Dan gee hulle mos vir ons `n salaris want ons hoef dan mos nie disability te kry nie.”

“Look we do not want money for free, let us also do a job through Tygerberg. Then they will give us a salary then we will not need to get a disability grant.”

4.2.4.2.6 Skilled job placement strategies

The participants felt that the decisions of individuals such as shopstewards, health and safety representatives and human resource departments determined their future worker roles. If these decisions or assessments were inaccurate then alternative job placement strategies were limited. As one participant said:

“I say right supervision and more care from people you have chosen like shopstewards and health and safety representative and human resource management. They should do their job. In other words this is the case where the doctor says you are fit again for a job but you are a panelbeater, you can no longer do panelbeating but you can still do spray painting.”

Participants were of the perception that the back injured individual should be treated as if he or she is unique because of the variation amongst the individuals' physical and psychological characteristics. One participant became frustrated when he was placed in a job that he was uncomfortable with. He said:

“Toe sê ek kyk hier maar ek gaan nie heeldag in `n kantoor sit nie ek sal mal raak. Ek is gewoon om buite te werk. Toe het my baas my buite laat werk.”

“So I said look here I am not going to sit for the whole day in a office, I will lose my mind. I feel comfortable working outside. So the manager allowed me to work outside.”

The participants became frustrated when their employers placed them in jobs that were not suited to their abilities. They felt that their productivity improved within the workplace when employers adapted their work routines according to their individual functional abilities and characteristics.

4.2.4.3 Category Three: Stakeholder transparency to aid programme development

The category explains the importance of having stakeholder (e.g. physician and employer) transparency in matters affecting the back injured individual. Reference is made to transparency regarding the pathology of the back injury and the work environment.

The participants felt that if stakeholders were transparent then there would be a speedier return to work after their back injury. However, when there is a lack of transparency between the medical professional, employers and the back injured worker, problems developed. As one participant said:

“Hulle het mense laat kom van Grootte Schuur Hospitaal spesiaal om te kyk waar ek seer gekry het, hoe dit gebeur het hoe` t ek gemaak en of ek dit aangemeld het, al daai dinge. Maar op die einde van die dag toe loop alles dood want ek weet nie wat hulle met bestuur gepraat het nie hulle praat met jou een storie dan kom hulle by bestuur dan praat hulle`n ander storie.”



“They had people come from Grootes Schuur Hospital especially to see where I have injured myself. How it happened and if I had reported it, all those things. But at the end of the day everything resulted in a dead end because I don` t know what they were talking to management about, as they will tell you one story then they would go to management and present a different story.”

4.2.4.3.1 Employer and physician transparency regarding the individual`s back condition

One participant was of the opinion that the employer and physician were responsible for transparency issues. He stated that he had proof of his incapacity however, when he took his medical retirement papers to the employer, these got lost and his claim was not validated. He therefore felt that most of his problems could have been avoided if the medical sectors and business sectors were more transparent with the injured worker. This is especially important if the physician in charge could contact the employer and explain the back injured individual`s

condition, as he was suppose to take his patients future into consideration. The participant said:

“So geval is daar twee mense wat fout het. Dit is jou werkgewer en jou dokter. Ek werk met altwee van ek glo aan dinge wat ek gesien het. Ek het bewyse van al my papiere, ek is gebord, die papiere werk toe gegaan maar niks het daar gebeur nie.”

“In such a case there are two people that have the problem. It is your employer and your doctor. I am working with both because I believe things that I have seen. I have proof of all my papers, I am medically boarded, the papers went to the work but nothing happened there.”

Another participant replied that she experienced a lack of transparency regarding the employer’s involvement with the treating physician. She reported that the employer was quite friendly towards her but in actual fact they were distrustful. In her situation the employer sent someone to the hospital in order to validate her condition without her knowing. She felt as if they were trying to question her honesty and formulate plans for her future without her involvement. She said:

“Agterna toe het iemand met die suster gesit en sy wil met die spesifieke dokter praat nou by Tygerberg oor jou. Dit is wat hulle as jy voor hulle kom is hulle baie mooi met jou, hulle het sympatie met jou maar as jy jou rug dan draai, draai hulle ook teen jou.”

“Afterwards somebody went to sit by the sister and she wanted to speak to that specific doctor at Tygerberg. This is what they, if they come in front of you they are very nice, they have sympathy with you but if you turn your back then they turn against you.”

Honesty from physicians was regarded as important because of the strong relationship that developed between the physician and patient. Participants felt that they could have accepted and adjusted to their back injury, if they were thoroughly informed about their back condition. As one participant said:

“Vir my het hulle gesê as hy `n fisie doen op my rug na ses maande dan is dit so te sê normaal. Ses maande na die fisie moet hy `n diskektomy doen want toe sleep my been van hulle moet, ek voel hulle moes net eerlik wees en sê jy sal nie meer dieselfde, moenie `n mens hoop gee nie.”

“To me they were saying if they did a fusion on my back then after six months I would be so called normal. Six months after the fusion so he had to do another discectomy because then my leg was dragging along the floor. I feel that they must be honest and say that you will not be the same, don't give a person hope.”

4.2.4.4 Category Four: Healthy work environments

Health promotion was seen as important in reducing and preventing future workplace injury. One participant felt that he had to live with his injury and that the best form of treatment for him would be not to have injured himself at work. The participant said:

“I have to live with this back pain there is nothing anyone can do, the best thing would have been not to get injured in the first place.”

One participant explained that the injured workers could be used to educate other workers about injury prevention after they had completed rehabilitation programmes. He said:

“Die poskantoor is so dom, meneer dat die vir my wat al daai kennis het dat ek nie my kennis en wysheid kan omskep by die werker nie. Ek sit met `n kop voel kennis maar die wysheid ek kan nie vir die mense sê moet nie dit so doen nie. You don't have to work harder you have to work smarter.”

“The post office is so stupid, sir that myself with all my knowledge cannot use this knowledge to improve the workers. I’m sitting with a head full of knowledge but I cannot tell the people don’t do things like that. You don’t have to work harder but smarter.”

The participants felt that if workers were satisfied with the environmental conditions of the workplace then they would be more productive. Happiness amongst back injured workers could be ensured by means of ensuring that the work environment is safe by preventing accidents, injury and promoting health within the workplace. One participant said:

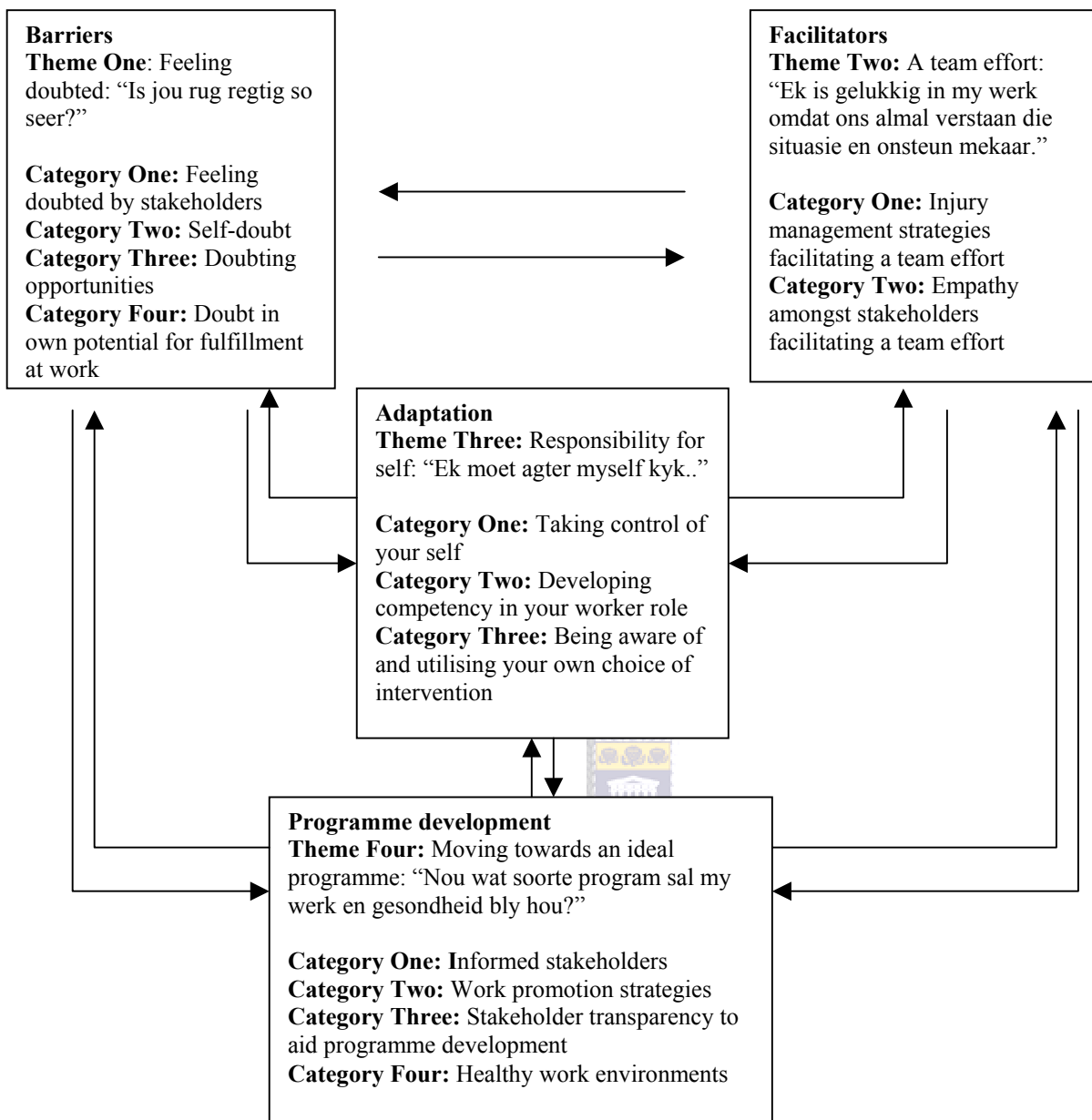
“Die mense moet gelukkige werkers hê dan sal ons produktiewe werkers hê, ons moet in `n veilige omgewing werk waar ons kan weet waar ons, ons kan seer maak. Ons wil weet dat die werk ons gesondheid eerste sit”

“The people must have happy workers then we will have productive workers, we must work in a safe environment, where we will know where we might hurt ourselves. We want to know that the work puts our health first”



This above quotes coincided with the health promotion principle of building a healthy environment where acute medical conditions are prevented from becoming chronic and where injuries are prevented.

Figure 1 : Diagrammatic framework of themes and categories



4.3 Conclusion

By drawing on the back injured individuals` experiences and perceptions of returning to work, the study objectives were achieved. Theme one and theme two respectively presented the participants` perceptions of the barriers and facilitators that influenced the return to work process. Theme three presented the participants` perceptions and experiences of their adaptation to their worker roles. Theme four presented the participants` perceptions of an ideal return to work programme. The diagrammatic framework (see Figure 1) indicates how the themes are interrelated,

for example participants viewed the absence of a facilitator to be a barrier and inversely the absence of a barrier to be a facilitator in the return to work process. Barriers and facilitators within the context of the study influenced the participants' perceptions of adapting to their worker roles, for example a barrier could impede or negatively impact on the adaptation process whereas a facilitator aided or positively influenced the adaptation process. Participants viewed adaptation (theme three) as a process that enabled them to utilise the facilitators and therefore overcome the barriers when returning to work. Finally theme one (barriers), theme two (facilitators) and theme three (perceptions and experiences of adaptation) directly influenced the success or failure of theme four (work programme development). Return to work programmes were viewed as successful when these programmes utilised the facilitators and the individuals' mechanisms of adapting to overcome the barriers. It was viewed as unsuccessful when the return to work programme failed to incorporate the latter.



5. Chapter Five: Discussion

In this chapter the barriers and facilitators that impacted on the participants' return to work will be discussed. The findings of the study will be related to the Model of Human Occupation in order to assist in the analysis and to show how the facilitators and barriers affected the back injured individuals' worker roles. Finally an adapted version of the Atomic Model, called the Atomic Model of Balance will be used to describe and discuss the participants' perceptions and experiences related to their adaptation when returning to work. This model will enable the researcher to identify the stakeholders who are in contact with the injured as well as their relationships that developed during the return to work process. The model will highlight the importance of positive relationships, effective communication, continued education and balance within the stakeholder orbitals as well as improve insight into the barriers and facilitators that contribute to the employee's performance within the work sector. The Atomic Model of Balance will also identify how and why back injured individuals attach meaning to their worker roles. This in turn will develop the focal point of intervention for this population.



5.1 Barriers

The findings in this study suggested that there was considerable agreement amongst the various participants with regard to what individuals experienced as barriers. The theme "feeling doubted," explains the barriers that prevented the participants from adapting to their worker roles.

The barriers will be discussed in terms of the stakeholders such as the person, employer, insurance company and society. These stakeholders will be discussed in this order to provide a systematic way of viewing how the barriers affected the participants. A section dedicated to discussing the communication processes between the stakeholders will then follow.

5.1.1 Stakeholder perspective: Person

Fisher (1994) reported that the psychosocial maladjustment and the emotional well being of the injured worker could be reflected in perceptions created in response to negative or counter productive social factors. From the data collected it was

evident that the participants' perceptions of themselves regarding their ability to perform work related tasks were either negative or positive. Participants often reported that the negative perceptions of employers, family and society caused them to lose confidence or develop a perception of doubt in their functional ability.

Doleys & Gochneaur (1989) explains that not everyone who was injured developed chronic pain. Rather, a sense of external locus of control during activity participation resulted in feelings of inadequacy and this depicted itself in the worker being unable to manage pain. From this perspective it can be deduced that an extrinsic sense of control whereby the participant's belief in him/herself in resuming his/her worker role was influenced by the perceptions of others within the environment. This belief influenced the individual's feelings of self-efficacy while performing work related tasks. Bandura (1983, 1989) argued that self-efficacy expectations are potent influences on motivation. Some of the participants within the current study were poorly motivated to return to work after the injury. This poor motivation could be viewed as a result of barriers such as their doubt in opportunities after the injury. The participants felt that they were not competent in executing work tasks that they had previously done. They interpreted the sub category "doubt in function and abilities as a result of pain" as a perception of fear in that they felt that recurrent injuries would lead to increased pain and limitations that could affect their financial and social lives. This perception resulted in the participants avoiding tasks within the workplace as well as losing confidence in their own potential and abilities. These findings coincide with that of Fritz and George (2002) who investigated fear avoidance beliefs, and concluded that these were important determinants in predicting the participant's success in rehabilitation programmes. This therefore indicated that participants who feared reinjury might have difficulty in completing rehabilitation programmes and could be at risk for prolonged work restrictions. However, Forman & Murphy (1996) viewed the individual as a conscious agent who actively interprets environmental demands and acts in accordance with these perceptions. The implication is that the individual develops an internal locus of control when he/she receives positive feedback from the environment and develops a positive self-concept as well. This positive self-concept is depicted in the attitude of participants while completing

rehabilitation programmes and when returning to work. Participants were of the perception that a positive attitude and intrinsic motivation aided them in successfully completing rehabilitation programmes.

5.1.1.1 Lack of abilities and skills

Physical, psychological and psychosocial stressors of work

Physical, psychological and psychosocial stressors were found to perpetuate mechanical stress in individuals that were engaged in repetitive work (National Institute of Occupational Safety and Health, 1997). These stressors were evident in the current study especially when the participants' functional abilities and skills became limited because of their back pain.

5.1.1.1.1 Physical stressors

According to Skov (1996) there is a relationship between musculoskeletal disorders such as repetitive strain injuries and occupations such as cashiers or grocery checkers. The physical components of a job can therefore be seen as possible causes for injuries sustained at work. Participants within the study mentioned that they experienced problems with the physical components of their jobs particularly when they had to work at lower surface areas and with different weights. They felt that the tasks at work placed repetitive or forceful strain on their spines that resulted in low back pain. The back pain that participants experienced could be related to an increase in pressure on the intervertebral disks of an individual's spine. This pressure causes a rupture in the intervertebral disc, that resulting in a herniated disc and inevitably back pain (Roozee, 1990).

The participants felt that their employers had no empathy for their reduced abilities as they were not capable of maintaining the productivity standards within the workplace. Some participants in the study were blue-collar workers (classed as manual labourers), and these workers often engaged in physical activities that had a detrimental effect on their spines over the years of employment. One of the most debilitating conditions affecting the back injured individual is osteoarthritis, which is a condition that causes a degeneration of the articular cartilage between bones. This degeneration of the cartilage results in pain, limits the range of movement of the affected joints and limits the strength of muscle that supports the joint (April,

1990). An imbalance in strength of para-vertebral muscles contributed to the back injured individual's functional limitations. This functional limitation was experienced by the participants as an inability to bend in order to pick up weights, walk over long distances at various speeds and when reaching for objects at various heights. Abnormal body mechanics^a often resulted in individuals not performing activities as efficiently as they did before the injury.

5.1.1.1.2 Psychological and psychosocial stressors

Vromen and MacRae (2000), in their controlled psychological and work factors study, reported that it is accepted that work related psychosocial factors are linked to muscular skeletal disorders such as back pain. The authors argued that anxiety and depression are reported simultaneously as primary and secondary to the development of repetitive strain injuries.

According to Karasek et al (1979) the interaction of physical and psychological job characteristics contributes to psychological strain, which in turn leads to physiological illness. Karasek et al (1981) claimed that occupations with high demands, low decision latitude and social support present the greatest risk to health problems. The latter was evident in the participants' lack of involvement in decision-making within the workplace (e.g. the majority of participants within the current study were not involved in alternative job placement strategies after they had been injured). This resulted in feelings of depression when returning to work, as they felt unhappy and not properly trained to do the work.

The participants' perceptions and experiences of depression are congruent with the demand-control theory that explains that stress, anxiety and depression develops when there is incongruence between work demands and the employees' ability to control the work demands (Karasek & Theorell, 1990).

^aThe readers of this thesis are referred to Larson and Ellexson (2000) for further reading with regard to the biomechanical postures or conditions that can affect the lower spine within the workplace.

According to Marhold et al (2002) depression is a major element in chronic back pain syndrome. Participants felt that depression affected their work performance secondary to the back pain. This depression would manifest itself in them losing motivation to participate in tasks not only in the workplace but at home as well. Participants reported that they had to seek professional help from a psychologist in order to take control of their lives.

Some participants reported that they were afraid to live with recurrent pain especially when society did not recognise the suffering that they endured. They felt despondent when they got to work in the morning as well as when they arrived at their homes in the evening as they could not execute tasks without experiencing pain.

A 100% effort from the back injured individual could not be initiated simultaneously within the workplace as well as at home as they did not have the functional capacity to do this. Participants explained that if they got home in the evening they often experienced fatigue in their lower backs due to the repetitive nature of their jobs. This resulted in conflict within the home environment especially as their relationships with their family deteriorated. Similarly, Sternbach (1974) explained that despair and despondency gradually develops if the suffering remained partially unrelieved and usual activities become restricted. He further claimed that a time protracted pattern is established involving helplessness and depression that reinforces pain behaviour. Within the current study employers and co-workers were often unsupportive of the participant's condition. The participants explained that a lack of reasonable accommodation within the workplace caused them not to be productive within the workplace. This caused their co-workers to become frustrated as they had to do "double the work" by completing the participant's work as well. As co-workers complained to employers about the unproductivity in the workplace feelings of depression were reinforced amongst the participants.

5.1.1.2 Age and education of the back injured individual

Age and educational status were viewed as being inversely proportional to employability (i.e. the older and less educated the individual the harder it was to

find employment). Participants were of the perception that their poor education, back pain and the fact that they were not “young” negatively impacted on their ability to find jobs. It could be argued that the poor education of workers contributed to the high unemployment statistics in the Western Cape which in 2002 escalated to 380 000 working age adults that were unemployed (S.A. Dept. of Labour, 2002). Therefore employment opportunities for the older back injured individual with a poor education level are often limited.

5.1.1.2.1 Age

According to Roozee (1990) changes such as the intervertebral disk that becomes brittle occurs as a result of the normal ageing process. This therefore makes human beings more susceptible to back problems as they become older. Back injuries have been cited as the most expensive healthcare problem in the 30-50 year age group and the leading cause of disability in adults under 45 years of age (Kelsey et al, 1978). In the current study the majority of the participants were in the age bracket of 36-60 (see Table 1 on pg. 24), it could therefore be argued that the older the individual the more prone they are to injuries within the workplace. The study participants expressed doubt in return to work strategies, as injury preventative strategies were not reducing the accidents within the workplace due to the work tasks being too strenuous. This is evident in research conducted by Isernhagen (2000) who stated that if the work was physically demanding then the workers would experience overexertion and thus increase their chances of injury within the workplace. Participants felt that employers had no empathy for their reduced functional abilities because of their age, as employers demanded the same productive outputs from the older workers as what they did from the younger employees. This caused strain on their spines and resulted in consequent hospital visits and absenteeism from work. Employers then used the incapacity due to ill health clause within the labour law in order to medically board the employee. Once the employee is medically boarded or dismissed from the workplace then he/she experienced extreme difficulty in finding work. This was evident in the attitude of employers who were perceived as doubting or discriminating against employees due to their age and back injury.

5.1.1.2.2 Education

Factors such as education, profession and earning status may influence not only an individual's ability to work but also the ability to acquire and keep a job (Christiansen & Baum, 1997). Within the current study the participants reported that employment in low paid blue-collar occupations remained limited, and this was seen as a result of the participants' back injury as well as their level of education. Participants in the current study felt intimidated by the privatisation of jobs as employers often employed higher educated workers (e.g. high school certificate holders). The latter is indicative of the barriers when returning to work such as the categories "self-doubt" and "doubt in opportunities" where participants lost confidence in their own abilities. These findings are congruent with those of Christiansen and Baum (1997), where they stated that the worker's self-perception of vocational capacity and attitude about his/her motive to work affects his/her self-efficacy and indirectly their work skills.

5.1.2 Employer and the workplace

5.1.2.1 Attitude of employer

Friesen et al (2001) mentioned that not only the management style of the employer but also his/her attitude affects the success or failure of the injured employee when returning to work. The authors also explained that an authoritarian style of management or attitude allowed little room for flexibility regarding workplace policies such as absenteeism and productivity standards within the workplace. They further explained that a participative style of management or co-operative attitude allowed employees to be more comfortable in expressing their needs within the workplace. These needs often coincided with workplace policies and were seen as imperative in improving productivity within the workplace.

The attitude of the employer was seen as having a huge impact on the injured employee's ability to maintain their employment status. The relationships between employer and employee could be seen as being a facilitator or a barrier. In the sub category "feeling doubted by stakeholders", the participants often referred to the employers as having an unsympathetic attitude, lacking empathy and doubting their abilities. If employers displayed this behaviour the injured employees would either fear going back to work, by adopting the sick role or by becoming angry

and frustrated. When the attitude of the employer was unsupportive then positive relationships within the workplace deteriorated and the result was an unsupportive work climate and a consequent decrease in work productivity.

5.1.2.2 Lack of education on disability management by employers and rehabilitation professionals

The participants within the current study were of the perception that the doubt that employers and medical professionals had in their back injury was because of a lack of disability management knowledge. They felt that they needed informed managers and physicians especially with regard to injury management strategies. Most participants felt that the physician had to educate the manager about the supportive role that the manager had to take once the patient became fit for duty. The manager should be the one to educate the workers in the workplace and should understand and thus facilitate the injury management process with the employee. The physician or rehabilitation professional should take the responsibility of educating the employee and the manager by using material that is simple to understand and making him/herself available for practical demonstrations. Participants felt that the workplace policy was user friendly only when employers were directly involved in rehabilitation processes and were educated about the multifaceted nature of their condition. Friesen et al (2001) revealed similar findings, whereby they explained that education has an important role to play not only in educating the managers and physicians about injury management but also the union members as well. They found that although the policy involving job accommodation was in place, many stakeholders needed to be educated about its effectiveness as well as how to apply it in the workplace.

5.1.2.3 Inadequate workplace policy

The Occupational Health and Safety Act was implemented as law in 1993 in order to prosecute employers or employees who disregarded safety policies within the workplace (Occupational Health and Safety Act No. 85 of 1993). However, the realisation of whether these acts were implemented as law within the workplace remains questionable.

The sub category “doubting workplace policy” referred to policies within the workplace that prevented the participants from adapting to their worker roles. Inadequate occupational health and safety policies within the workplace were seen as an example of a negative workplace policy. The participants felt that their injuries could have been prevented if they were working within a safe environment (e.g. many workers attributed their injuries to the repetitive nature of the work as well as the use of unsafe equipment).

According to participants, employers manipulated the process of reasonable accommodation to their own advantage. It was seen as a tool to exploit and discriminate against the worker. Participants in the study felt that they were unfairly dismissed due to ill health and this claim could be validated as many of these participants were not reasonably accommodated which by law, should have been enforced by the employer (Labour Relations Act No. 66, 1995). The participants viewed the process of affirmative action with great scepticism as they felt that it only selected the previously disadvantaged race groups for work opportunities. Most of the participants had the perception that they could not get jobs because of their back injury in addition to the discrimination against their skin colour. They felt that black Xhosa speaking individuals were given preference to jobs and that the Employment Equity Act reinforced this process. The participants felt that the labour policies within the workplace did not allow them the opportunity to find jobs.

5.1.2.4 Political and economic constraints

Friesen et al (2001) claimed that the economic and political constraints that affect the worker often limited the potential for modified work within the workplace. Barriers that were caused by poor co-operation between stakeholders (e.g. employer, medical profession and the family) included political and economic constraints such as unfair labour practices and the pressure of productivity standards within the workplace. Irregular labour practices such as unfair dismissal or not being regarded for employment opportunities and promotions were mainly determined by workplace productivity standards. Participants felt that they could not keep up with the productivity standards in the workplace due to their back pain relapses. They felt that because privatisation was becoming more apparent, their

chances of maintaining employment became blurred. The latter is indicative of the category “doubt in own potential to be fulfilled at work” especially when the participants were encouraged to accept a medical board by shop stewards who were unethically influenced by managers. If positions were available to them within the workplace then managers would employ younger physically fit employees.

5.1.2.5 Lack of meaning and satisfaction in work

In a study conducted by Brown et al (2001) they acknowledged that the meaning attached to work by an individual was significant because of the degree of satisfaction that the individual derived from their work. The sub category “doubt in finding meaning in the worker role” is indicative of participants who were placed in jobs that caused them frustration, as the jobs had no meaning to them. When these meaningless tasks were to be coupled with the back pain relapses then there would be a downward spiral into depression and demotivation.

However, on the other hand, other participants felt that to be able to work was seen as a privilege particularly because of the growing competitiveness of the private sector and the constant rise in unemployment within the country. One participant felt that he was not regarded as part of society as he could not contribute financially to society. He further stated that when he was employed, only then could he regard himself as a man, but now that he was medically unfit to work, society regarded him as disabled. Guevra and Ord (1996) reported that individuals found meaning in work that was unique to their personal experiences. Locke (1976) explained that the more frequently a worker achieved highly valued outcomes within the workplace the greater the satisfaction they experienced. Participants in the study tended to be satisfied with their jobs at certain times however, when they experienced problems with the working environment then satisfaction with their jobs decreased. Some participants argued that although they received minimal benefits, such as poor pensions and salaries, they were forced to put their injured bodies through the pain due to the financial debt that they had accumulated after the back injury. Another worker stated that she was losing out on an opportunity to prove herself to her employer due to her high rate of absenteeism as a result of the back pain relapses. This caused her to develop doubt

in herself and her job, as she was not being promoted within the workplace when she compared herself to her colleagues. Locke (1976) reinforced the above statement when he argued that fewer opportunities with the aim of achieving a valued outcome often result in lower levels of satisfaction. It could therefore be claimed that satisfied workers are more likely to exhibit increased productivity.

5.1.2.6 Lack of employment and retraining opportunities

Employability refers to the back injured worker's ability to become employed within a particular labour market (Matheson, 1989). The role of employment in an individual's life is a complex and important one as participants felt that it enabled them to fulfil basic biological needs for food and shelter. Employment becomes problematic to the participant when they have back pain as they struggled to resume their work duty or when retraining themselves for work.

The category "doubting work retraining" could be viewed as a result of employers not facilitating retraining within the workplace. The concept of workplace rehabilitation is either something new to the employers or they simply don't have the funds to hire the services of a qualified health professional such as an ergonomist, occupational therapist or physiotherapist.

Retraining of the back injured worker was seen as a foreign concept to the participants within the study, as it either never took place, or they were placed in new positions at work for the sake of keeping them occupied. This resulted in the participants having feelings of dissatisfaction with their new work placement and consequent poor work performance. The participants were not trained appropriately for the job, and their compatibility to the new job and its requirements was not taken into consideration by the employers. Their functional capacity did not permit them to skillfully execute the job demands. This resulted in the premature dismissal of participants, as opportunity within the workplace remained limited. These results are similar to that of Friesen et al (2001) where employers felt that they could not retrain or accommodate the injured workers due to a shortage of jobs.

5.1.2.7 Poor matching of the worker and the work

One of the most important reasons for accurate employee and job matching is to prevent any future injuries from occurring. Isernhagen (2000) reported that the prevention of work related injury or illness is a high priority for parties such as the employer and medical professional who are directly involved with the injured. She further explained that the injured worker's condition that is not managed well or matched to the physical demands of the job could develop into a chronic or disabling condition. Mckenney (2000) reinforces the latter when he argued that effective treatment approaches should focus on treating the injured individual within the context of the type of work that they were doing in order to decrease injury rates and improve productivity.

The sub category "doubt in accommodation within the workplace" is indicative of poor workplace strategies. Participants were of the view that their employers failed to recognise their true capabilities, which included individual preferences such as their likes/dislikes, their work potential and the status they had within society. One participant explained that he previously worked as a mechanical assistant for a company. His employer accommodated him in the workplace by moving him to a department that was foreign to him and where he was responsible for domestic duties. As a result he became disheartened with the move and lost interest in his new worker role.

5.1.3 Medical profession

5.1.3.1 Negative attitude of the medical profession

The attitude of the medical profession could be seen as a facilitator or regarded as a barrier in the rehabilitation process. The attitude that the medical profession had towards the participants was interpreted as a barrier as it caused them to be intimidated or become frustrated with the medical system. The fact that Compensation Boards were unresponsive to the payments of claims, caused medical practitioners to become frustrated when there was a delay in reimbursement. Participants felt that these medical practitioners tended to handle them without empathy and regarded them as poor paying clients. This resulted in feelings of disempowerment and passivity. Participants felt ashamed to assert

themselves by not questioning health professionals about the quality of treatment they received often causing them not to complete their rehabilitation programmes.

5.1.3.2 Poor medical treatment

The sub category “doubting the efficacy of surgical treatment” is indicative of the frustration that patients developed as a result of poor outcomes after surgical interventions. Historically, treatment of low back complaints had consisted of either surgical intervention or conservative care characterised by bed rest, muscle relaxant medications and passive physical therapy exercises. Participants felt that physicians had been promising them recovery from pain but afterwards found that this was untrue. For the participants that developed chronic pain syndromes they perceived themselves to be untreatable. This was often exacerbated by their poor financial status in society. Watts (1989) investigated the development of pain after repeated surgery. He claims that after surgical intervention the individual usually abides by the physicians’ instructions and because of this the employer and the insurance company were more understanding about the back injured individual’s condition. He further stated that the patient who recovers after surgery is the same patient that would recover with no surgical intervention. This was because inactivity, which lasts for 3-6 weeks, allows for adequate wound healing to occur, not as a result of surgery but because of the forced physical inactivity. Therefore, the patient who continued to have pain after the surgery was as a result of a misdiagnosis (ibid, 1989).

5.1.3.3 Lack of client-centeredness

Client centeredness is defined as the holistic treatment of the individual who is also the primary decision maker in the treatment process (Sumsion, 1993). Participants in this study referred to the management of their condition from a physical, psychological and emotional point of view. Their limited functional ability would in turn affect their daily life tasks such as washing, dressing and homemaking. After the participant had become injured it was the physician that initially came into contact with the client. The physician performs an assessment of the participant’s condition but fails to take into consideration the effect that the patient’s job requirements has on him/her as well as the psychosocial stressors that arises from the injury.

The physician was seen as the professional who advocated on behalf of the participant to the employer and to the family. Participants felt that the physician did not understand the client's work environment, such as what functional demands were necessary for the client to complete their tasks as well as the psychosocial stressors that could cause the individual's condition to become chronic.

Participants felt that there were financial problems that prevented them in completing their treatment. They felt that the physician did not explain to them the possibilities of utilising more cost-effective treatment interventions. The fact that rehabilitation professionals did not thoroughly assess the participant's home circumstances meant that they could not identify any underlying stressors that impacted on the person's prognosis. This therefore contributed to the poor rehabilitation outcomes that were experienced by the participants.

Friesen et al (2001) reported similar results to that of the current study where they concluded that the individuals in contact with the back injured had to listen to their complaints and try to understand their behaviour from their personal perspective. This would aid them as health professionals to achieve better treatment outcomes.

5.1.4 Insurance Company

5.1.4.1 Inefficiency of insurance companies

Amell and Kumar (2002) argued that insurance models utilised by Workman's Compensation should focus on prevention as the appropriate method of injury management before the injured worker becomes a claimant to the organisation. Sparks and Feldstein (1997) in their project with the Washington Department of Labour and Industries reported a 27% cost reduction with the use of managed care techniques including case managers.

The participants of the current study complained that the poor injury management strategies initiated by the insurance agencies caused a poor return to work rate and sometimes exacerbated the chronicity of the back injury. Lemstra and Olszynski (2003) supported the above results by stating that the insurance company that co-

operated with the employer and that reinforced early intervention had a lower incidence of injury claims.

Participants in the study frequently complained of delays and inefficiencies regarding the insurance systems administrative procedures. This resulted in delays in compensating the treating health professional (e.g. physiotherapists and physicians) as well as inappropriate injury management mechanisms. Participants also complained of the lack of networking and transparency between the insurance company, employer, medical profession and employee.

5.1.5 Society

5.1.5.1 Unsupportive society

Society within the context of the study consisted of the individuals within the participants' workplaces and their immediate families.

According to Cohen and Syme (1985) the lack of an appropriate social network aggravated the development of chronic diseases including back complaints. Depending on the manner in which society treated the participants, they could either feel supported or not supported at all by society. In the current study some of the participants viewed society as being judgemental, unsupportive and discriminatory whereby others felt that they could not have rehabilitated themselves without the support of society. They felt that they were tired of being seen as different, as living with a condition that was regarded as psychological or being seen as dishonest about their experiencing pain. These findings are similar to the findings of Marhold et al (2001) who claimed that psychosocial factors such as low social support from society often results in depression and fatigue. These factors, when interpreted as a barrier, are viewed as an obstacle when the participant returns to work.

5.1.6 Poor communication between stakeholders

Communication is a concept often neglected and poorly emphasised by the worker, employer and affecting stakeholders. The participants felt that their communication with colleague's and manager's deteriorated after they had been injured. Communication in this context referred to the lack of communication

through which information is relayed amongst workers when meeting deadlines and in creating a supportive work climate. As the participants were frequently absent from work due to their back condition they were not informed by colleagues about changes in workplace policies and project deadlines if they enquired; they felt as if they were not regarded as part of the working team.

Friesen et al (2001) argued that lengthy delays in the communication process could always be viewed as a barrier in that they are detrimental to the return to work process of the injured. They further emphasise that these delays could be a factor in the development of secondary disability such as chronic pain syndromes. These delays in communication would be evident in the types of jobs that were allocated to the participants whereby their functional capacity did not match the components of the job. The problem was one of a vicious cycle whereby the employer would not inform the employee about injury management strategies such as informing them about where to send relevant documentation and in managing compensation procedures. After the medical and rehabilitation procedures had been completed the physician did not openly communicate with the employer regarding the nature of the patient's condition as well as the time period that the patient should be on light duty. The fact that the medical reports were written using medical terms that the employer could not understand resulted in the employer unsuccessfully trying to accommodate the injured worker within the workplace. This inevitably resulted in conflict between the medical profession, employer and employee.

Research conducted by Edwards and Marshal (2003) indicated that there is great tension between doctors and business managers as a result of their different approaches to workplace policy and productivity within the workplace. This tension could be seen as a result of a lack of networking and communication between the health professional and the employer. It is therefore essential that good communication between the stakeholders (medical professionals, employer, family etc.) directly involved with the back injured individual facilitate a speedier recovery and prompt return to work. This view is evident in studies conducted by Friesen et al (2001) where they reinforced the importance of having supportive relationships, regular communication and team-work amongst all involved

stakeholders. These stakeholders would include the insurance companies, the workplace manager, the injured worker, the occupational health professional and the family physician.

5.2 Facilitators

Facilitators are seen as factors or characteristics of the environment that promoted or enabled the participants to successfully adapt to their worker role after their injury. The facilitators will be discussed in terms of injury management, a positive work culture, work placement strategies, education within the workplace and holistic team management. There will also be an emphasis on facilitatory factors such as micro loans, seniority within the workplace and a meaningful/satisfactory work experience.

5.2.1 Environment

5.2.1.1 Injury management strategies

Participants that functioned effectively within the work environment often cited injury management as a facilitator. Injury management within the context of this study included effective communication and trust between the stakeholders that were directly in contact with the employee. This communication process included communication between the medical professional-employer and employer-compensation boards. This process was not in the form of a formal policy and was primarily based on positive interpersonal relationships.

The participants within the study explained that the interpersonal relationships between the stakeholders ensured that their rehabilitation procedures were regularly monitored and therefore fostered a speedier return to work rate. This finding is congruent with a study by Friesen et al (2001) where communication, teamwork, trust and credibility were found to be positive factors in returning the injured to work. These factors therefore determined the success in bridging the gap for the participant from rehabilitation programmes to participation in their worker roles.

5.2.2 Work

5.2.2.1 Positive work culture

A positive work culture was advocated within the support of workplace policies such as occupational health within the work environment. Measures of facilitating a positive work culture were interpreted in the employer's attitude towards the back injured workers. This included empathy and positive praise for the participant's effort. The participants within this study cited that their self-esteem and self-concept was pivotal in resuming their worker roles. They mentioned that acknowledgement of the quality of work they performed despite their injury served as a great motivating factor that eliminated job stress. Participants mentioned that being able to be promoted to alternative work placements and to receive their usual salary were also acknowledgement of their efforts. This is evident in the effort reward model, which explains that an imbalance between the amount of effort spent and the resulting reward an individual receives may lead to stress within the workplace (Siegrist, 1996).

5.2.2.2 Work placement strategies

Suitability of work placement after medical intervention was viewed as being a key component in allowing the participant to resume their worker role. Immediate and accurate placement within a supportive environment induced good results for the participants. They indicated that the work placement of the back injured individual had to take their work experience and the recommendations of the medical profession into consideration, as a measure to prevent them from reinjuring themselves. This finding is consistent with Isernhagen (2000) who identified matching of the work and the worker as a pivotal step in reducing injury and increasing productivity of the workers. Hazard et al (2000) reported that patients in her study unanimously agreed that they should remain as active as possible after the injury, and that workers who do not return to work after injury are more likely to become disabled. In the current study, appropriate work placement acted as a facilitator in the return to work process as it provided the injured employee with more opportunities.

5.2.2.3 Education within the workplace

Hazard et al (2000) acknowledged that efforts that could prevent disability should include education of the worker within the workplace. This has to include assessment of the informational needs of the injured and should also focus on the type of work that is effective in reducing disability among both acute and chronic patients with back injuries.

The education of the participant was seen as a formal or informal mechanism that improved the insight of the workers in preventing injury or in accommodating them within the workplace. This could be in the form of shop-steward education sessions or informal conversations between workers. Topics could range from the administrative procedures involved in processing an injury claim, identifying the role players involved in the injury management process and prevention of injuries within the workplace.

5.2.2.4 Micro loans within the workplace

Participants were without work for weeks or months and this resulted in tension within the household especially when it was the breadwinner who was injured. Rehabilitation and consequent medical procedures were seen as costly, not only economically but also socially. Participants felt that in order to sustain their daily living expenses they contacted employers to make micro loans. This service was seen as a facilitator in that it enabled them to pay their childrens' school fees and it provided money for transportation to rehabilitation facilities. These micro loans therefore enabled these participants to complete rehabilitation programmes.

5.2.2.5 Seniority within the workplace

It has been proven that low decision latitude combined with either a high level of demand or a low level of social support of fellow workers and supervisors are risk factors for ill health (Spector, 1987). Seniority within the workplace, workplace experience and being seen as a benefit to colleagues facilitated a perception of empathy and support for the participant. One participant remarked that he had a responsibility to his employers and that the other workers saw him as someone special, someone they could rely on when they needed help. He explained that

because of his seniority within the workplace, other workers treated him with respect even though he had a back injury.

5.2.2.6 Meaningful and satisfactory work experience

Meaningful workplace experience was seen as a tool that could be used to educate other workers about the job and its requirements. Participants felt that they could be called upon to work in any department because they had developed competence within their work. One individual explained that he developed a love for his work because of the satisfaction it gave him particularly when he could compare the quality of his work to that of others.

The meaning of work became apparent to participants especially if they had caring managers that supported them by contacting the physician to enquire about their prognosis. This therefore created a feeling of appreciation and empathy from the employer and co-workers for the participants.

5.2.3 Holistic team management

Holistic team management is indicative of the theme “a team effort” and this included co ordinating services as a team, from the physician to the rehabilitation professional. This also included appropriate and swift referral within the correct time period (i.e. the patient should not be referred to the rehabilitation professional if his condition has deteriorated to the extent that chronicity has developed). Participants felt that after the organic and inorganic basis of the condition was treated then appropriate ergonomic intervention had to commence. This did not necessarily have to be an expensive process however basic work routine adaptation and improving the insight of the employer regarding patient handling was seen as helpful.

5.3 Relation to the Model of Human Occupation

Kielhofner’s (1992) Model of Human Occupation (M.O.H.O) explains that human beings function within an open system that is in constant interaction with the environment, which is composed of objects, tasks, social groups and culture. The interaction is influenced by the state of three subsystems - volition, habituation and performance.

According to Hammel (1999) M.O.H.O offers a framework for analysing occupational roles. The occupational role of an individual as a worker is of particular importance in the current study and it is for this reason that the model was used as a method of explaining the conceptualisation of factors influencing job success.

5.3.1 Volition

According to Kielhofner (1992) the volition subsystem refers to the human need to explore the environment, and achieve mastery over tasks and the course of life. Kielhofner et al (1998) explained volition as consisting of the following namely personal causation, values and interests.

5.3.1.1 Personal causation

According to Kielhofner et al (1998) individuals with a strong sense of efficacy will accept responsibility for their own performance, learn from their mistakes and generally accept success.



However, the participants in the current study felt that they were not as effective or efficient as what they were before the back injury. They developed a negative self-image during, as well as after, the rehabilitation process and this was reflected in their perception of doubt in their functional abilities. Participants felt that they did not have the functional capacity to execute tasks that they previously did, without reinjuring themselves. The pain relapses therefore reinforced their feelings of dysfunction in the occupational area of work. This aspect of the model coincided with the participants' poor self-efficacy beliefs that contributed to their strong sense of external locus of control. This external locus of control was reflected in the participant's doubt in being fulfilled at work as they felt that they were not able to find a job that suited their abilities even if they were to be reasonably accommodated. They tended to inaccurately measure their own strengths and weaknesses by fearing pain and relying on the perceptions of employers and colleagues to improve their self-esteem. This resulted in negative perceptions whereby the participants felt that there were no other occupations that would be able to sustain their functional ability.

5.3.1.2 Interests

Kielhofner et al (1998) stated that interest is an individual's attraction to something or what one prefers to do. They acknowledged that vocational interests are important influences on what type of work people choose to do. The enjoyment of physical labour, intellectual challenges and interacting with people are examples of why people choose certain jobs and why they find work interesting and satisfying.

Participants in the current study thought that it was not worth it to carry on day- by day doing the same repetitive work and enduring the negative attitudes of colleagues and managers. Their interest in work tasks was essential to the development of meaning and satisfaction in their worker roles. They became frustrated when they lost their interest in a task particularly when the work environment was not conducive to the nurturing and development of their potential capabilities. Some participants in the study had alternative interests that gave them meaning in life such as leisure interests and some even created self-employment opportunities.



5.3.1.3 Values

Kielhofner et al (1998) define values as one's world-view and what is important within this world-view. The authors acknowledged that individuals valued differences in the type of work they did due to psychological values of whether work provides structure, social contact, feeling of competence and a creative outlet.

Participants in this study had different opinions about what they valued in their worker roles. Some of them felt that their work allowed them to form part of society in that they were able to sustain their families. Others felt that work gave them structure to their day whereas unemployment made them bored with their lifestyles. Participants in this study had undergone rehabilitation for their back condition because they valued work so highly. They felt that in order to form part of the working culture they had to take control of their lives by completing rehabilitation programs. The awareness and utilisation of rehabilitation choices were seen as pivotal to the participants. They were open to options such as

workplace modifications, physiotherapy, home programmes and alternative arrangements at work after the injury.

5.3.2 Habituation

Kielhofner et al (1998) defined habituation as the process that enables the individual to maintain a pattern of regularity in everyday life. Habituation consists of two components namely internalised roles and routine habits of doing things.

5.3.2.1 Internalised roles

Internalised roles are defined as role related behaviour that causes the individual to appreciate social situations, expectations and develop behaviour that enacts a given role (Kielhofner et al, 1998).

Kielhofner et al (1998) stated that sometimes, negotiation of the worker role is informal such as when co-workers agree on how to share responsibility for a routine task. Other times it is formal as when a written job description is altered or an evaluation identifies the failure of a worker to meet certain expectations.



Participants in the study developed a perception of doubt in their worker roles. This was manifested in their inability to work as a team with other stakeholders in reinforcing suitable work placement and reasonable accommodation within the workplace. They felt limited with regard to their current functional abilities especially when executing work tasks. Some participants had to adjust their lifestyles according to their residual abilities and had great difficulty internalising their new roles. The work that they were doing also shaped their personal interests and worker roles. These interests that they had were seen as a manner of internalising their worker roles. The opposite however occurred when participants had conflict with managers and supervisors especially when this was related to their chronic condition. This was explained in the negative attitude that the employer had towards the participants. Participants had the perception that employers could not realize why they could not complete tasks due to pain, as their pain was regarded as non-existent. They felt that their pain was misinterpreted as laziness, lack of commitment/dedication and dishonesty. This

misinterpretation of the participant's pain therefore resulted in them losing interest in work and not internalising their worker roles.

5.3.2.2 Habits

Habits are explained as routine patterns of doing tasks within one's performance areas. (Kielhofner et al, 1998)

The participants remarked that productivity was a job demand that impacted on their ability to perform their routine tasks. As they could not perform the functional components of their tasks as they did before the injury, they struggled in maintaining their daily routines at work. The sub category "Self-doubt" could be explained in terms of the back pain relapses that resulted in concentration problems, which affected their daily routines not only at work but within their home environment as well. Participants often remarked that they could not survive without some form of assistance whether from a family member or from a colleague at work. They became frustrated with themselves and people around them because of this disruption in their daily routines.



Kielhofner et al (1998) recognised that when habits clashed with workplace organisation or expectations, the individual may need to develop new habits in order to avoid failure. As one participant mentioned that her daily routine was disrupted after her back injury. She had to get up early in the morning in order to prepare supper for the evening because her back was too painful when she returned from work. Other participants felt that their routines in the workplace became altered in that they had to bring their work tasks home in order to manage their workload. Some participants within the study reported that they had "too much" free time available after they had been medically boarded. They either spend the time sleeping all day or reading magazines. This indicated that the participants balanced their use of routines and time around their worker roles. They became familiar with these adapted routines through extreme planning that was often time consuming.

5.3.3 Mind-brain-body-performance

According to Kielhofner et al (1998), the Model of Human Occupation does not provide a detailed account for underlying capacity. They recommended that the Model of Human Occupation be used in combination with other models of practice that explain motor, biomedical or cognitive deficiencies. The assessment of back injured individuals often involves biomedical approaches whereby components of function such as range of movement, muscle strength, sensation and proprioception were assessed. Therefore, as the participants in the study were not thoroughly assessed by the researcher in terms of the above mentioned components only their explanations regarding their functional abilities will be clarified.

Kielhofner et al (1998) mentioned that performance capacity is one factor along with volition and habituation that influences adaptation to occupational roles. Participants in the study often complained of pain relapses that limited functioning in their worker roles; this could be explained by the organic basis of their condition. The organic condition can be interpreted by the peripheralist's view that pain is produced by an underlying mechanism such as a pinched nerve that can be eliminated. This view of pain is however contradictory to the centralist view, which argues that factors such as poor socio economic conditions, family problems, emotional and intellectual variables are the cause of pain (Tollison & Kriegel, 1989).

Participants within the current study frequently complained of radiating pain that they experienced from their lower back into their lower limbs. Some of them were relieved from the pain after surgical intervention whereas others felt that the pain still persisted after the operations.

Inorganic symptoms can therefore be explained by the centralist view that pain resulted in feelings of inadequacy and depression. Some participants reported that they constantly experienced anxiety and depression that caused them to seek professional help in order to maintain their functional abilities.

The participants felt that physiotherapy and pharmaceutical intervention assisted them in the remediation of their physical capacity. They felt that other professionals such as psychologists, occupational therapists and chiropractors were helpful in treating their condition.

The symptoms or limitations the participants experienced impacted on their personal causation where they developed a perception of doubt in their own abilities and potential to be effective within the worker role. Their adapted lifestyles whereby they had to juggle work routines, take responsibility for medication use and at the same time physical therapy programmes impacted on their daily routines. As a result of these adaptation processes conflict (e.g. relationship problems) developed between the participants and the environment.

5.3.4 Environment

Kielhofner et al (1998) defined this concept as consisting of the physical and social environments in which the individual finds him/herself.

5.3.4.1 Physical environment



This includes the physical space in which the individual works and the objects that they come into contact with (Kielhofner et al, 1998).

Participants in the study often complained about the physical components of their work occupations such as carrying, walking, bending and reaching. They tended to experience the most difficulty when it is expected of them to continue with these aspects of the tasks without any attendance or help. However, when the work area was adapted to their comfort needs they functioned adequately in their worker roles. This could explain how ergonomics and energy conservation impacted on their abilities to perform within the work atmosphere. Ergonomics is the science that deals with the matching of the worker to the work (Pheasant, 1991). This involved structural adaptations within the workplace, the restructuring of work routines and biomechanical methods of doing tasks and the redesigning of equipment for workplace utilisation. The participants that were successfully employed after the injury have, to some extent, incorporated principles of ergonomics in order to maintain their worker roles. Some of them modified the

equipment that they were using themselves and health care professionals, such as the occupational therapist assisted others in doing the same at their workplace.

5.3.4.2 Social environment

According to Kielhofner et al (1998) the social environment consisted of the individual's work environment (i.e. co workers, colleagues and clients) as well as the various social groups that the individual comes into contact with.

Participants within this study placed emphasis particularly on the social interactional processes within the work and home environment. Therefore, this aspect was either seen as a barrier or a facilitator. The negative attitude of co-workers and managers was perceived as a barrier that caused participants to devalue themselves. Some participants reported that they felt as if their actions were being judged and constantly monitored, as employers wanted to build up a case in order to demote or retrench them. Others felt that when they tried to excel within their worker role then their role as a care-giver deteriorated (i.e. the back pain and fatigue they experienced negatively impacted on their ability to spend time with loved ones). Participants mentioned that an unsupportive family was seen as a barrier that caused them to lose confidence in themselves. The sub category "Doubt in workplace policies" was explained within the context of the corrupt political system within the work environment. Participants felt that unfair employment practices such as affirmative action and the stigma relating to their condition prevented them from functioning as independently as they possibly could.

Kielhofner et al (1998) mentioned that workers, who had the perception that they were valued, supported and rewarded for their efforts had a stronger motivation for continuing with work. This indicated that work satisfaction and commitment to work were linked with acceptance and respect from co-workers.

The participants in the study did not appreciate a sympathetic feeling from family members and colleagues as this resulted in feelings of inferiority. Participants felt that they expected empathy not sympathy and they wanted people to view them as individuals facing challenges just as anyone else.

5.3.4.3 The M.O.H.O feedback mechanism

Kielhofner et al (1998) explained that work behaviour should always be recognised as a feedback system between the person and the environment. This feedback system involved the interface of the capacities, roles, habits, interests, values and personal causation of the worker with the conditions in the workplace.

It is from this context that the occupational dysfunction of the injured worker can be explained. Many participants agreed that although they tried their best in rehabilitating themselves, they lacked the support from their home and work environment in order to adapt successfully. This resulted in the disruption of their personal causation, habits and ultimately their worker roles. As stakeholders such as the family, employer, medical professional and insurance companies failed to communicate with each other regarding the participants` rehabilitative procedures, they could not devise effective injury management strategies to return the injured to work. The participants within the study felt that they constantly received negative feedback from environmental sources, and they felt that their return to work processes could have been more successful if there was transparency between the participant and the environment. This resulted in the physical and psychosocial demands of the job to exceed the functional capacity of the participant.

Similarly Kielhofner (1992) explained that the open-system cycle that maintains the individual becomes interrupted if the individual is at risk for further degeneration when the environmental demands exceed functional capacity of the injured individual. Therefore, the person with motor difficulties (back injured) would experience an exacerbation of problems if he or she fails to overcome environmental stress.

5.4 Adaptation

According to Frank (1996) adaptation is a process that consists of adaptive responses that are learned through experiences or engagement with challenges arising both internally and externally. Adaptation within this study referred to the participants` perceptions and experiences of achieving optimal performance in the workplace despite the disabling back pain.

The M.O.H.O provided a thorough analysis of the back injured individual's worker role however the model does not adequately explain how the participants adapted when returning to work. The M.O.H.O provided insight into the effect of the environment on the back injured individuals' functioning however it did not specifically explain the relationships between the individual and stakeholders such as the employer, family, insurance company and medical profession. It was for this reason that an existing atomic model was adapted to explain the participant's perceptions and experiences of adapting to their worker roles after the injury.

5.4.1 Elements of the Atomic Model

Lovell et al (1975) explain that the atomic model consists of an atomic core that is defined as a positively charged (proton). It is surrounded by negatively charged electrons that are attracted towards the positive core as a result of the opposite charges in an atom that attract one another (ibid, 1975). This attraction gives the atomic molecule a stable electron configuration that could be interpreted as a sense of balance within the orbital structure. In the universe everything has a tendency towards balance. This is evident in the theory of Sir Isaac Newton where he revealed that for every action in the universe there is an equal but opposite reaction (Giancoli, 1991). Based on these concepts, the Atomic Model of Balance was devised by the researcher to illustrate the process of adaptation, incorporating a systems approach. This approach consists of the following orbital systems - the individual's orbital system, the work orbital system, the medical orbital system, the family orbital system and the insurance orbital system.

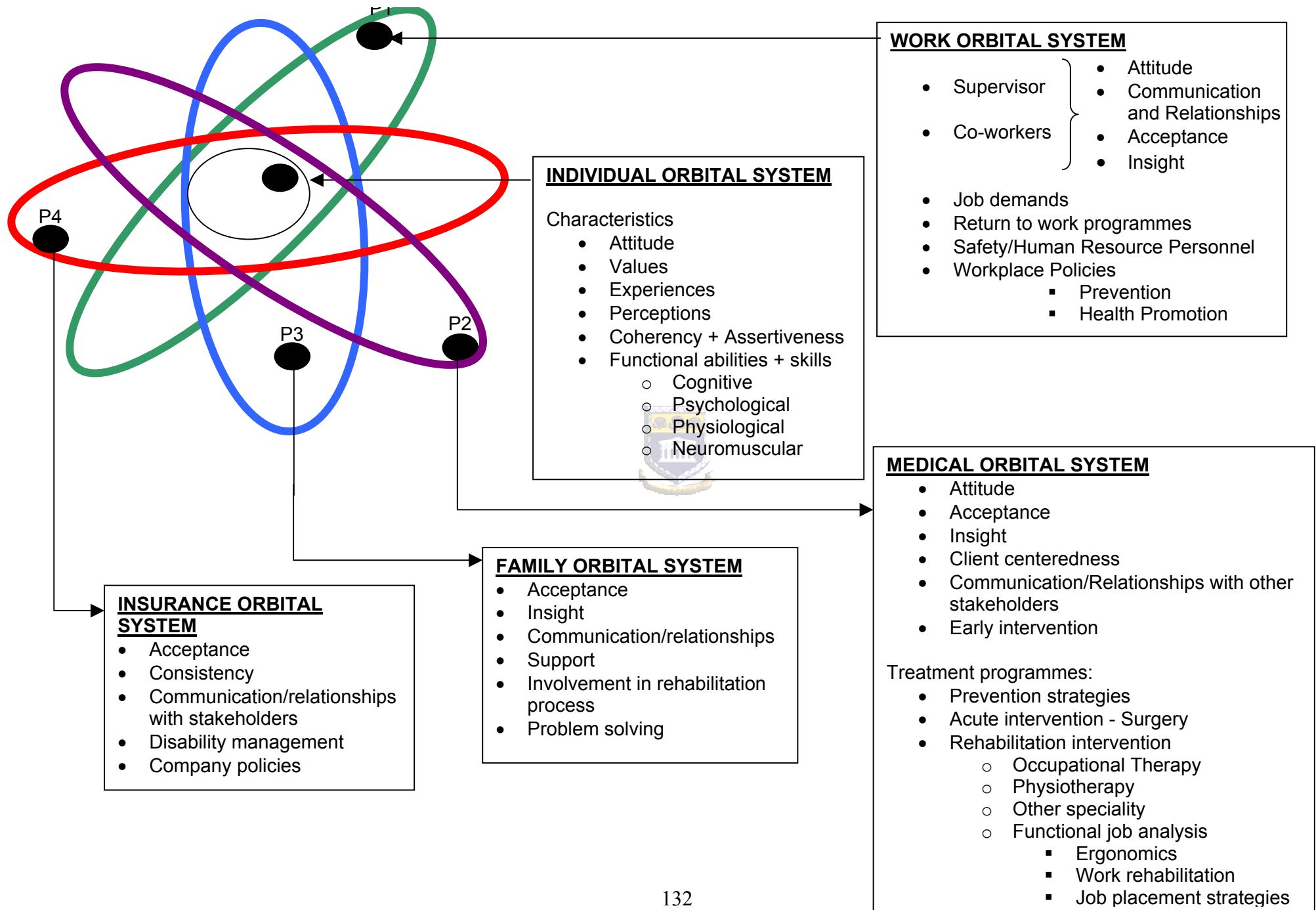
5.4.2 Introduction to the Atomic Model of Balance

The adapted Atomic Model of Balance (see Figure 2, page 132) demonstrates that equilibrium is maintained only when there is successful interaction between the electrons (work orbital system, family orbital system etc.) and the inner core (individual orbital system). If the movement of some electrons around the inner core becomes disturbed then there will be an imbalance in the energy field and stress will result. In this study stress could be interpreted by poor medical intervention strategies, lack of employment opportunities and poor family support. This in turn has a negative ripple effect on the individual who may then experience stress.

Communication between the orbital systems is regarded as important. Miscommunication between the orbital systems results in the balance of the atom to become altered. Therefore, in order to maintain equilibrium the recognition of all orbital systems has to be taken into consideration.



Figure 2: THE ATOMIC MODEL OF BALANCE- ADAPTED FROM THE MODEL OF THE ATOM BY LEVEL et al 1975



5.4.2.1 Individual orbital system

5.4.2.1.1 Positive core

This consists of the participants' inherent characteristics such as their personality, attitude, beliefs, experiences and perceptions. Reference will be made to the concepts of coherence and, assertiveness as well as the participant's functional abilities.

5.4.2.1.2 Person-attitude

Participants cited that a positive attitude was very important during and after the rehabilitation process. The attitude enabled them to remain positive and to complete the rehabilitation procedures. This was reflected in the way participants undertook tasks at work and at home whereby they incorporated biomechanical principles within their everyday lives. They emphasized that programmes were time consuming and that they would sometimes be tired when they had to complete home treatment programmes when they arrived at home from work. However, they persevered and remained consistent in their approach to their health. Acceptance of their condition emotionally enabled participants to cognitively adapt to their lives. This cognitive adaptation took the form of undergoing therapies whether physical, psychological or pharmacological in order to return to previous functioning levels.

However, to the contrary, the participants who had a negative attitude towards treatment and rehabilitation procedures would experience a form of disruption. This negative attitude would have a ripple effect in that it affected all the other orbitals such as the family orbital system and the medical orbital system. Example the negative attitude of participants (individual orbital system) to rehabilitation (medical orbital system) often causes them not to successfully complete rehabilitation programmes that directly impacts on their ability to return to work. If these individuals are unproductive at work (work orbital system) because of recurring back pain or reinjury then they are dismissed ultimately causing family conflict (family orbital system) because of the loss of finances within the household.

5.4.2.1.3 Experiences and perceptions of oneself

The participants' past experiences were seen as motivators for their participation within work related tasks and rehabilitation programmes. Participants who knew that their employers and family were supportive had no problem in abiding by treatment programmes. They would in turn internalise their worker roles and motivate themselves to return to work after the injury. Those participants that took control of their lives tended to be more successful in adapting to their worker roles. This could be explained by the theories of internal locus of control and self-efficacy (Bandura, 1983). However the participants with a strong sense of external locus of control and poor self-efficacy would develop a perception that they could not cope with life's demands thus resulting in them not fulfilling their worker roles. This therefore reinforced a negative feedback mechanism of disruption and maladaptation.

5.4.2.1.4 Coherence and assertiveness

Merze et al (2001) defined coherence as the process that enables the individual to become motivated, to develop capacity to persist in the face of adversity and to develop a sense of confidence in his/her problem solving abilities in the workplace.

Merze et al (2001) stated that coherence is used as a measure to revert negative thoughts that might lead to workplace stress, to attributes that promote workplace health. Participants often mentioned that they needed to be assertive in order to negotiate employment opportunities at work. They felt that if they did not talk to their employers about their functional abilities and continue utilising the incorrect body mechanics, they would end up reinjuring themselves. With regard to the workplace policy, some of the participants made it their responsibility to adapt after the injury by educating themselves around these policies so that they would know what procedures they should follow if they were injured on duty. Some of them developed their own medical-legal files in which they compiled their own medical reports. This therefore enabled them to personally liaise with Workman's Compensation regarding compensation benefits, thus enabling a speedier return to work process.

5.4.2.1.5 Abilities and skills

Rehabilitation procedures such as physiotherapy or occupational therapy improved the participants' intrinsic abilities and skills. These abilities included muscle strength and range of movement in limbs that was needed in order to complete tasks concerning everyday living and fulfilling their worker role. There was a need to increase endurance levels and effectively manage their pain whether with pharmaceutical or psychological intervention. This resulted in the participants incorporating biomechanical skills (such as correct lifting, bending and gripping strategies) within work related tasks. Problem solving abilities were seen as a measure of adapting within the workplace as problems were identified. Participants mentioned that they would modify their routines as well as their equipment as the need arose. This enabled them to eliminate stress on their affected joints and save the company the cost of employing professional ergonomists.

5.4.2.2 P1 Work orbital system

According to Moon and Sauter (1996) the individual's level of control over job demands could be linked to the levels of stress that they experienced as workers (i.e. if the job's requirements exceeded his/her abilities then he/she will experience stress within the job).

Participants in this study frequently mentioned that tasks involving heavy weights had a detrimental effect on their back condition. However, when the participants carefully assessed the types of occupations they participated in, then feelings of poor motor control and monotony were reinforced. This subconsciously affected their ability to return to work after the injury. Smith et al (1999) in examining the effects of monotonous activities on employee health reported that repetitive monotony (e.g. assembly line work) tends to be hazardous to one's health in general. They report that less skilled workers are at greater risk of increased job stress especially with the introduction of new technologies. This was evident in this study where participants emphasized the view that machines and younger educated workers caused them to fear losing their jobs. The role of the employer within the entire rehabilitation process cannot be overemphasized. Participants were of the perception that the more effort and concern an employer puts into the

injured workers rehabilitation the more rapid their recovery would be. Some participants felt that employers had to support them as they were injured while on duty. Employers who actively facilitated relationships with medical professionals by asking questions regarding the participant's prognosis and who supported them throughout the process of recovery enabled them to become more loyal, faithful and productive employees. The participants developed a sense of pride in companies that encouraged any form of return to work program compared to employees of companies with no programmes. Employers that enforced the Occupational Health and Safety law and who educated workers on a regular basis were seen as actively advocating on behalf of the injured employees. Therefore, the participants felt encouraged to participate within the work environment when it was conducive to their health.

According to Wicken (2000) factors such as the fitness of the individual, prevention and health promotion were seen as measures of eliminating injuries within the workplace. Fitness of the individual referred to cardiorespiratory endurance, skeletal muscular strength, skeletal muscular power, speed, flexibility, agility, balance, reaction time, and body composition. These components of function were seen as pivotal in executing tasks within the workplace.

Many participants within this study had the perception that back injuries could be minimized as a result of the prevention efforts of occupational health committees within the workplace. These committees ensured that employees worked in a safe environment and with equipment and material that were not hazardous to their health. They also acted as a mediator between the employer and employee after the back injury as well as when the employee had to be reasonably accommodated within the workplace.

Preventative measures could be grouped into primary, secondary and tertiary measures. Primary prevention measures involved the prevention of disease in an at risk population, secondary prevention involved the reduction in the severity of diseases and tertiary prevention referred to the limitation of the degree of disability (Wicken, 2000). In the workplace setting it would be unrealistic to apply all the preventative measures. Participants within the study therefore viewed,

primary preventative measures such as health promotion as the most suitable measure of intervention.

O'Donnell (1986) described health promotion as the science and art of helping people change their lifestyle to move towards a state of optimal health. Health promotion strategies could be established through awareness programmes, lifestyle change programmes and the creation of a supportive environment.

It is therefore argued that barriers such as the doubt that stakeholders had in the participant's condition could be eradicated through health promotion policies. This eradication would in turn lead to the utilisation of appropriate intervention strategies that would assist in decreasing the rate of injury within the workplace.

5.4.2.3 P2 Medical orbital system

The medical orbital system played an instrumental role within the lives of the back injured individuals. Participants felt that they had to equip themselves with the knowledge and skills concerning all medical decisions. They had to educate themselves on the anatomy of their bodies as well as the factors that contributed towards the functioning and deterioration of their bodies. They had to openly communicate with physicians and rehabilitation professionals regarding the advantages/disadvantages of surgery and use of medications. They felt that they had to be competent with the medical system in such a way that they would be able to teach colleagues and family members about their condition.

Participants felt the need to personally mediate between the medical professional and the employer because of the poor communication between these stakeholders. In doing this, the participant would get transparent information regarding their chances of suitable employment as well as avoid mixed signals between the medical professionals and the employer. This in turn improved the insight of medical practitioners into the psychosocial aspects of the participant and facilitated client-centeredness in rehabilitation programmes

Choices in surgical or rehabilitation interventions were viewed as important, as participants felt that having a second opinion was helpful particularly when they

were not sure of the quality of care that they were receiving. Prevention of injury within the workplace was seen as the most common intervention strategy in minimizing back injuries. However, when an individual injured him/herself then a systematic process of intervention should be followed in preventing the back injury from becoming chronic. In the acute phase of the injury, surgery and medication was usually advocated for first followed by rehabilitation strategies (e.g. physiotherapy and occupational therapy). After rehabilitation had been completed then work test placement strategies followed by ergonomics in the workplace was advocated.

Failure to successfully manage this orbital system created a ripple effect that negatively influenced all other orbitals. Lemstra and Olszynskis (2003) reinforced the concept of early intervention of the back injured individual where they claimed that Worker's Compensation injury claims were reduced considerably by early effective occupational intervention.

5.4.2.4 P3 Family orbital system

In research conducted by Johnson (1991) and Karasek (1990) respectively they identified that social support, whether at home or in the workplace, has a role in reducing workplace stress. It acts as a buffering mechanism between stressors and health and it meets basic human physiological needs for companionship and group affiliation that is essential to health and the acquisition of knowledge of the individuals abilities.

Roy (1989), in his research on couple therapy, acknowledged the importance of the family in the remediation of the chronic back pain condition. He mentioned that the family associates a variety of meanings to a family member, and that family dynamics can contribute not only to perpetuate the back problem, but also cause it to become worse.

In the present study the participants perceived the family as a motivating variable that either facilitated or served as a barrier to the back injured individual's participation in their worker role. The participants expressed that a lack of family support after their back injuries served as a barrier in the return to work process. A

strong sense of family involvement acted as a facilitator when it aided the participants in practicing their rehabilitation programmes within the comfort of their homes and when it served as reminders to persevere in their efforts. In this study the participants expressed the view that they had to reorganize their lives not only at work but within the family context as well and this resulted in feelings of guilt within themselves as their family responsibilities were not fulfilled. The fact that family members still remained supportive was evident in behaviour such as organizing the home environment so that it was more manageable for the participant to do tasks at home. This family support facilitated the transition from their back injured status to independent functioning within their worker and family roles.

5.4.2.5 P4 Insurance orbital system

Within the study, participants had the perception that medical insurance agencies had to administrate rehabilitation procedures after an individual was injured. This would then aid the worker in returning to work and limit medical compensation pay outs.



Friesen et al (2001) reported that the insurer could play an important role in the implementation of rapid and effective communication strategies among all systems affecting the back injured especially between the insurer-physician, insurer-employer and insurer-worker.

Participants in the study explained that it was the insurance system that often impacted on their future abilities for example the acceptance or rejection of an injury claim. This claim determined the payment and completion of rehabilitation programmes. The system was characterized by a lack of transparency, weak communication channels and ineffective response rates. Participants that were injured on duty decided that the only way to adapt to this system was to educate themselves about the operating procedures of insurance companies. They asked questions about the administration procedures involved, contact persons and follow up procedures. Participants felt that they had to seek legal advice or assistance in order to speed up payment processes. They often developed an independent system for themselves whereby they would keep records of all

treatment intervention reports because their information often got lost at these insurance companies.

The problems experienced by the participants were consistent with findings of Franche and Krause (2002), who argued that poor claims handling processes of insurance companies often resulted in individuals not completing rehabilitation procedures. It is thus accepted that the insurance orbital has an important role to play in ensuring equilibrium between the medical orbital system, individual orbital system and work orbital system.

5.5 Recommendations for the development of a return to work model

For the purpose of the thesis the specific recommendations for the development of a return to work model will be explored in chapter six.

5.6 Issues for occupational therapy practice

Traditional medical practice has been focused on a bio-medical model of rehabilitation whereby the individuals' components of functioning were remediated in order to participate within their occupational roles such as a worker, homemaker, sportsman etc. (Smithline & Dunlop, 2001). Occupational therapy practitioners within the private as well as the public sector are often pressed for time because of the huge client loads they have to deal with. This often results in occupational therapists struggling to execute holistic evaluation procedures such as determining the effects of the work environment and home environment on the back injured individual's functioning. Occupational therapy practitioners are in the favourable position of being able to incorporate holistic evaluation and intervention within a person performance environment frame of reference (Baum, 1991). However, practitioners who wish to pursue a career in the complete assessment and treatment of the injured employee need to attend special courses on ergonomic evaluation of the injured worker's workplace and improve their insight on government regulations (e.g. employment equity, code of good practice, the process of reasonable accommodations and workplace safety). Insight into these courses and government regulations will allow the occupational therapist to empower their back injured clients with regard to their legal rights within the workplace as well as allow them to adapt and maintain their worker roles. With

the increase in employees taking legal action against companies regarding workplace injury and unfair dismissal, occupational therapists could be called upon in the future to provide expert legal testimony based on the individual's work functioning. It is therefore imperative that there is continued education with regard to back injury assessment and treatment techniques within the post-graduate university programmes. This study aimed to develop a greater insight into the challenges that face the back injured population. The findings of the study indicate that the goal of occupational therapy and the scope of practice with back injured clients require reconstruction.

5.7 Intervention strategies

The findings indicated that the participants that were successful in returning to work after the injury process had a supportive environment at home as well as within the workplace. It implied that the barriers that affected the injured were mainly environmental in origin and that these barriers were seen as problematic when it affected the participants on a personal level. Most of the participants in the study presented with a strong internal locus of control and this was evident in their ability to take responsibility for their own rehabilitation. However, they had to adapt despite working within a poor work environment. To them they persevered by finding meaning in the work they engaged in, through accurate job placement strategies, being one's own injury manager and having a strong value system that allowed them to continue with their tasks.

The fact that most of the participants in the study were unemployed and relied on disability grant benefits (currently valued at R620 per month), emphasized the importance of remediation of the chronic back disability. The therapist, with his/her knowledge of pathology and work placement strategies, has a huge influence on the occupational rehabilitation arena. It would be his/her responsibility to allow the injured individual to accurately identify their problems and assets in terms of abilities and appropriately match this to job demands

The participants within the study presented with limitations regarding the physical components of their functioning such as bending, carrying and climbing. This caused the back injured to experience an increase in back pain. The therapist

would in turn assist the back injured in modifying the individual's physical and psychosocial work environments. Physical modification was seen as modifying the equipment and structural surroundings of the employee to match his/her functional abilities. The psychosocial modification was seen as educating the employer and the client regarding the negative affects of an unsupportive working environment on the back injured individual. The therapist would therefore be able to consult with other health professionals and employers regarding the most suitable work placement and handling strategies of back injured individuals.

Health promotion was seen as a possible frame of reference in order to build a supportive environment for back injured individuals. The back injured individual's workplace and place of residence were seen as examples of supportive environments where the prevention of back injuries and reinforcement of treatment programmes could be introduced.

Back injured individuals are currently at risk for not realizing their potential by not utilizing their full psychological and physical capacity within the workplace. This capacity within the context of this study could therefore only be remediated by the development of a supportive social and working environment.

6. Chapter Six: Conclusion and Recommendations

6.1 Conclusion

The study highlighted the participant's experiences and perceptions of barriers and facilitators that influenced their ability to adapt to their worker role when they returned to work. The barriers identified in the study centered around "Feeling doubted", and included: feeling doubted by stakeholders, self doubt, doubting opportunities and doubt in own potential for fulfilment at work. Facilitators within the study that aided the participants after the back injury included injury management strategies and empathy that contributed to facilitating a team effort.

Rehabilitation and assessment processes focused mainly on the physical capacity of the participants, often ignoring personal and interpersonal factors that are critically important in worker role fulfillment. The findings of the study indicated that the back injured individual's condition is multi-faceted and that no single health professional can claim unique contributions to the successful rehabilitation of the back injured worker. The Model of Human Occupation (MOHO) provided a useful theoretical framework for occupational therapists, as well as other health professionals, in analysing the back injured individuals worker role. It offered a holistic approach in work training, treatment and management of the injured within a person performance environmental context. The MOHO provided insight into how the injured workers' characteristics such as their personal causation, habits and performance components could be positively or negatively affected by the environment. It also magnified the importance of networking and communication in successful injury management strategies.

The findings of this study will enable the stakeholders to realise the perceptions and experiences of the injured regarding the supporting/non supporting factors within the healthcare, family and insurance systems that facilitated worker role adaptation after the back injury. The study also allowed the participants to provide recommendations to improve the quality of care that they are currently receiving.

Adaptation within the study was seen as a process that was dynamic and uniquely perceived by each individual. Adaptation to the worker role was facilitated by

constant interaction between the back injured individual and the environment. Factors influencing adaptation within the context of the study included holistic injury intervention strategies that encompassed intersectoral collaboration between the business sector, insurance sector and medical sector. Participants in this study attributed the adaptation process to their sense of personal causation or self-efficacy beliefs in taking control of their lives, developing competency in their worker roles and being aware of/utilizing choices. These were related to environmental systems such as the work environmental system, medical system, Workman's Compensation system and the family system. Participants that depicted dysfunction or maladaptation presented with an inability to manage the latter systems within the environment.

In order to reduce the threat of dysfunction to their worker roles, participants tended to compensate by seeking external support such as assistance from their employers, families and government assistance (i.e. disability grants). This finance was used to sustain their basic needs while they were trying to explore employment opportunities. Participants that maintained their worker roles despite the environmental challenges developed a strong sense of meaning in their work. This meaning related to the individuals' strong values and morals that they developed within themselves.

The findings indicate that in order to be therapeutic, the treating health professional needs to totally evaluate the person, utilising a holistic work integrative approach particularly when the individual is employed. Holistic evaluation of the individual would include the evaluation of daily tasks within all the affected performance areas such as activities of daily living, work and leisure. This injury management process should be monitored over a period of time where collaborative decision-making between the individual and the various stakeholders needs to be implemented.

The organisational structure of the work environment tended to contribute immensely to the recovery and eventual return to work processes of the injured. Furthermore, the minimization of back injuries was largely influenced by health promotion strategies within the workplace.

6.2 Recommendations for the development of a return to work model

One of the objectives of this study was to provide recommendations for the development of a return to work model. The Atomic Model of Balance was developed on the basis of the findings of the study. This Model provided an explanation for the interaction specifically between the back injured individual and his/her environment, and could be used to develop a concise return to work model of practice.

The following recommendations for a return to work model were therefore based on the Atomic Model of Balance:

- A return to work model of practice should focus on assessing and treating the back injured individual within the context of the Worker's Compensation system, work system, medical system and family system.
- The model should offer a potential foundation for exploring the relationships between the individual, group, system and societal levels of operation. This could be achieved by the utilisation of disability management programmes.
- The model should focus on methods of disseminating knowledge on prevention. This could be in the form of Health Promotion initiatives such as the education of the individual as well as other workers with regard to prevention of injury within the work environment.
- The model should focus on client-centeredness when exploring assessment, management, treatment and retraining procedures. This would include:
 - Client-centered assessment of the back injured individual's circumstances and demographics when planning intervention strategies.
 - Client-centered work process management of back injured employees regarding their work routine such as flexibility in working hours and work task variation.
 - Client-centered treatment/training procedures such as introduction of choice in approaches such as ergonomics, occupational therapy and psychology together with traditional biomedical approaches.
- The model should incorporate cost effective and evidence based treatment strategies through the development of the following:
 - Training multi-skilled professionals who are competent not only in their background professions such as physical therapy or medicine but in

holistic evaluation of the client within a person performance environmental context.

- Development of an injury management or disability assessment team that could develop intervention strategies that involve stakeholders such as the work system, medical system, insurance system and the family system. This team could have the functions of planning, monitoring and evaluating intervention strategies.
- The introduction of workplace evaluation and workplace modification strategies.
- Introducing subsidised employment strategies to supplement work placement within the unemployed back injured populations. This would act as an incentive to encourage individuals to complete work training procedures.
- The model should recommend that the individual who has sustained a back injury return to physical activity as soon as possible. A set time period after the injury was difficult to estimate due to the multi faceted nature of the condition. However, employment within a reduced capacity was seen as essential in returning the injured person to work, preventing acute conditions from becoming chronic and preventing deficits in the back injured worker's role.
- The model should suggest that regular communication and transparent injury management policies between the stakeholders such as the workplace, insurance companies, medical profession and the injured individual are seen as an integral component of rehabilitation.

6.3 Recommendations for occupational therapy

- It is suggested that occupational therapists assess their role within the wider context of the helping professions whereby they could become more involved in on-the-job evaluations, placements and training of back injured individuals.
- The back injured individuals spontaneously participated in problem solving processes within the current study. The occupational therapy role could be expanded to include these individuals in life-skill programmes as they presented with deficits with regard to assertiveness, coping skills, anxiety management and problem solving abilities. One way of improving the back injured individual's insight and fostering continued education would be the development of support groups within the community or within the workplace where collaborative learning could take place with the occupational therapist facilitating the groups.
- Based on Health Promotion principles the occupational therapist could advocate on behalf of the back injured during the acute stage of the illness with stakeholders such as the family and employer. This would not be solely the responsibility of the therapist but he/she should initiate the process to foster action in collaboration with other legal or health professionals. This would therefore form the basis of establishing return to work programmes within the workplace.
- The development of an injury management and prevention system that could be systematically developed for the benefit of both workers and employers. This would entail the objective and accurate measurement of the physical requirements of the job and functional capacity of the worker. An example of this could be the formulation of a "barriers to return to work" questionnaire. This questionnaire could be used to predict the individual's motivation to participate in programmes, identify risk factors before injury occurs and eventually predict sick leave. The questionnaire could also include the facilitators as it was identified within the study as this would serve as a mechanism to neutralise the barriers.

6.4 Recommendations for multidisciplinary intervention strategies

- It is suggested that return to work programmes improve the back injured individual's insight into the factors that impact on their medical condition such as the medical system, insurance system and family system.
- In order to prevent individuals from losing confidence in their work abilities, health professionals should enable individuals to manage their lifestyle issues and re-assess the values and beliefs they hold in terms of their back condition.
- Return to work programmes should focus on enabling individuals to see the value in taking responsibility for their own rehabilitation and employment issues. This could be achieved through client-centered practices.
- Surgical and rehabilitation strategies are to incorporate client-centeredness as the underlying principle of practise when remediating the back injured individual.
- It is suggested that an outcome based education programme be developed in order to evaluate and monitor the quality of back rehabilitation interventions.
- It is recommended that strategies incorporate continued education of the back injured and other workers within the workplace regarding health and safety.
- Research is needed to further develop and apply a return to work model to other populations and contexts. This would serve as a thorough exploration of the impact that stakeholders have on the injured individual's rehabilitation procedures.

6.5 Recommendations for occupational science

- Further research is needed to explore the underlying mechanisms that facilitate meaning in the occupational performance area such as work. This research would be imperative for understanding the adaptive processes involved when an individual is chronically ill and has to resume their worker role.

6.6 Recommendations for medical profession

- The Atomic Model of Balance could be seen as a valuable tool for practitioners to use in order to better understand their clients' psychosocial perspectives thus assisting with systematic evaluation and treatment planning.
- Undergraduate education programmes should include specific focus on issues such as compensation claims, disability laws and other legal aspects of care.

- It is also suggested that undergraduate education programmes be aimed at improving the insight of medical students regarding muscular-skeletal aetiology and the role that prevention has in reducing the physical, psychological, economic and social burdens that are imposed on the workers.

6.7 Recommendations for the business sector

- The lack of recognition of occupational disorders within the workplace is partly a result of a lack of transparency between the employer and the employee. It is therefore suggested that there be greater transparency and communication between employers and employees with regard to policies such as employment equity, reasonable accommodation and occupational health and safety.
- Poverty negatively influences the back injured individual's chances of successfully completing rehabilitation programmes. In order to counteract the effect of poverty on the return to work process it is suggested that employers have employees contribute to a disability scheme fund to assist them financially when they are in need.
- The incorporation of active return to work programmes within the workplace that can be monitored, controlled and documented by stakeholders (e.g. employer and health professional). These return to work programmes will take the form of partnerships with health care providers that could evaluate and adapt programmes as needed.
- In order to improve the return to work process, employers have to communicate with the medical and insurance sectors. This would facilitate specific case management of the back injured individual. Organisations such as Workman's Compensation would benefit from prompt communication about injured employees' performance within the work sector and the medical sector. This could result in a decrease in compensated expenditure, increase in productivity within the workplace and lower employee turn over rates.
- Participants in the study expressed the need to share their experiences with other employees. It is therefore suggested that experienced employees or professionals put health promotion mechanisms in place. This would enable them to educate the employers with regard to prevention issues, how to

navigate the complicated system of Workman's Compensation and the medical system.

- It is recommended that there be an improvement in management process techniques such as human resource management. An example of the latter could be seen in the form of team building amongst employees-employers. Another example could be in the creation of partnerships between safety managers and rehabilitation professionals trained in functional capacity evaluation and pre-work screening. This could result in more effective matching of the injured to the workplace.
- The utilization of marketing and outreach skills by the business sector to advocate a philosophy of health and safety. This would allow the companies to be viewed positively by the public.

6.8 General recommendations for government departments

- The recognition of individuals with chronic illness or disability, particularly those living in poverty to have equal opportunities to health services that are of a suitable quality. This could be achieved by strongly advocating primary health care and health promotion on a local and national level.
- Methods to be used in preventing the loss of the worker role could be in the form of subsidised income generating projects for those individuals that are unemployed. This project would have to be created in partnership with the business sector where individuals could have a fair chance of employment.
- The development of an injury management forum that has to be representative of the business sector as well as the health sector. This sector could operate on the principles of holistic management whereby organisations such as Workman's Compensation could be aided in planning, monitoring and the treatment of the injured.
- The development of an enabling climate through health promotion initiatives that could be facilitated through partnerships between the public sector and intergovernmental organisations.

In conclusion, the study highlighted that the back injured individual's condition need not be financially burdening to the individual, company and the economy if cost effective and goal orientated intervention strategies were to be exercised.

The challenge that lies ahead for occupational therapists is to implement strategies based on holistic remediation within the work setting. These strategies are not new to the profession and should be advocated within all areas of practice. The failure of occupational therapists to comply with their code of practice might result in a blurring of professional roles and result in a sense of injustice to the back injured individual who wants to resume his/her worker role.



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Appendix A: Participant Demographic Template

Characteristics	Tick where applicable
Gender	Male
	Female
Marital Status	Married
	Single
	Separated/Divorced
	Widowed
Age Range	18-35
	36-55
Type of living arrangement	Own home/apartment
	Boarding Home
Employment Status	Paid Work
	Volunteering
	Unemployed
Year of first experience with medical health system for back condition	1950-1959
	1960-1969
	1970-1979
	1980-1989
	1990-1999
Date of most recent hospitalisation	1980-1989
	1990-1999
Types of institutions where treatment was received	T.H. in-patient
	T.H. outpatient
	D.H.
	G.P
	B.R.F

Other

**Current experience with
health system**

T.H. in-patient

T.H. outpatient

D.H.

G.P

B.R.F

Other

T.H (tertiary hospital)

D.H (day hospital)

G.P (general practitioner)

B.R.F (back rehabilitation facility, back school)

Other (includes any other type of treatment intervention)



Appendix B: Letter describing the study

A research study is being conducted by a graduate student in the Masters of Science programme in Occupational Therapy at the University of the Western Cape, examining the ways in which back rehabilitated clients adapt to their worker roles after they have received medical intervention. Information gathered in this study may help to advance knowledge and intervention strategies regarding the treatment of back- injured clients. If you decide to participate in the study, the investigator will consult with you to arrange a suitable time for data collection. You will be involved in a group discussion and possibly a follow-up session.

The group discussion will consist of a number of questions, which will be presented to the participants as a group. Pending participant's consent, the sessions will be videotaped/audio-taped, and the investigator will be in the room facilitating the process. Since the information will be used in a research study you will be asked to give your written consent by signing a form. All research data will be kept in confidence by the investigator. Notes and tapes will be kept in a locked storage area. Tapes will be transcribed by a professional typist who is aware of the importance of maintaining confidentiality and who has signed an oath to confirm her knowledge of procedures to maintain this. All names and any other identifying details will be kept confidential, and anonymity is assured. Following the completion of the study, data will be maintained in a locked area and may be used for future research. You will not be identified in any publication or presentations of results of the study.

Your participation in the study is voluntary. If you agree to participate, you may withdraw your consent and discontinue your participation at any time.

If you have any questions before or after the study you may contact the investigator SHAHEED SOEKER at 082 7175432 or 9386152.

Appendix C: Letter of consent

I,, agree to participate in this research study investigating the perceptions of back-rehabilitated clients regarding their worker roles. I have received a letter of information about the study, the nature of it has been explained to me, and my questions have been answered to my satisfaction. I understand what will be expected from me.

PARTICIPANT:

.....

WITNESS:



.....

.....

DATE:

.....

Appendix D: Questions to participants of model one

Questions used in the 1st focus group of model one

- 1) Can you describe the problems or difficulties you faced after you sustained your back injury?
- 2) Can you describe the things that helped you to overcome the difficulties that you experienced after your back injury?
- 3) Can you tell me how, you adapted to your worker role?

Questions used in the 2nd focus group of model one

- 1) From your own experience, can you talk about what has been or would be helpful for workers to return to work after injury?
- 2) How can you remain healthy or maintain you fitness? Do you think people understand the circumstances that you are going through?
- 3) What would you think is the number one priority for people who provide you with medical care? What advice could you give to someone who is experiencing the same difficulties as what you did before?

Questions used in the 3rd focus group of model one

- 1) Tell me about apartheid and its effects on the worker before and after injury?
- 2) What aspects of your worker role give meaning and satisfaction to you as a worker?
- 3) How has age and level of education impacted on your role as a worker?
- 4) Job routine, how do you as workers feel about the current work system?
- 5) Tell me about the pace at which you worked and the structure of furniture/equipment you used?
- 6) Tell me about Health and Safety in your workplace?

Appendix E: Questions to participants of model two

Questions used in the focus groups of the second model

- 1) Can you describe the problems/difficulties you faced after you sustained your back injury?
- 2) Can you describe the things that helped you to overcome the difficulties that you experienced after your back injury?
- 3) From your own experience, can you talk about what has been or would be helpful for workers to return to work after injury?
- 4) Can you tell me how, you adapted to your worker role?
- 5) If you were asked by the people who decide what and how medical services are provided to you as a client, what would you suggest is the number 1 priority?