

**THE OCCUPATIONAL AND  
PSYCHOLOGICAL  
EFFECTS OF INJURIES ON MUSICIANS**

by

**CECILIA MARGA SIEBRITS**

**SBRCEC001**

A minor dissertation submitted in partial fulfilment of the requirements for the award  
of the  
Degree of Master in Music  
Department of Humanities  
University of Cape Town  
2005

**Declaration**

This work has not been previously submitted in whole, or in part, for an award of any degree. It is my own work. Each significant contribution to, and quotation in, this dissertation from the work, or works, of other people has been attributed, and has been cited and referenced.

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**SUPERVISOR: PROF. HENDRIK HOFMEYR  
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University of Cape Town

## ABSTRACT

### The Occupational and Psychological Effects of Injuries on Musicians

Cecilia Marga Siebrits

When musicians acquire injuries that interfere with their ability to play their instruments, it is not only the affected body part and physical symptoms that affect them. My own experiences following a wrist injury, that prevented me from playing the piano during my student years, prompted this study. I had hoped to become a concert pianist. These hopes were dashed when I realized that my wrist injuries were interfering with my ability to play the piano and resulted in emotional and psychological stress. As a result I had to re-evaluate my career choice.

In this qualitative study, I investigated the broader experience affecting the occupational and emotional health of musicians. For this purpose, I used the qualitative method of a focus group and reflection on my own experience.

A recognized theoretical model, the Model of Human Occupation, underpinned by the theory of human occupation was used as a framework.

The data was gathered through the use of a focus group discussion of three participants, including myself. The discussion was audio-recorded and transcribed. The analysis was done by coding the data for categories and searching for themes. I adopted a reflective stance by including an autobiographical account of my own experience.

The results revealed that the injuries suffered by the three participants had a vast impact on their occupational well-being as well as their psychological and emotional health. Two themes emerged from analysis of the data: *My injury affected my occupation* and *I was forced to adapt to an alternative occupation*.

## ACKNOWLEDGEMENTS

The author wishes to express her gratitude towards the people who assisted in the production of this study:

To my co-supervisor, Dr. Viki van Rensburg, for steady guidance and support.

To Dr. Bezuidenhout and Prof. Hendrik Hofmeyr for their contributions.

To the participants in my focus group, for willingly sharing their experiences in aid of this research.

To Dr Alex Lubet for his contributions and friendly support.

To my generous sponsors, Asher Kellmen, the Harry Crossley Foundation, Sylvia Gavron, and K.W. Johnston, without whom this study would not have been possible.

To my parents, Danie and Hettie, for steady support, encouragement and patience.

To Artur, for his support, inspiration and encouragement.

# **The Occupational and Psychological Impact of Injuries on Musicians**

## **Chapter One**

### **Overview of the study**

#### **1.1 Introduction**

This study was inspired by my own experiences in dealing with wrist injuries that prevented me from playing the piano - injuries that have caused me much emotional and psychological stress and have forced me to re-evaluate my career choices. As I am trying to come to grips with the consequences of this problem and the difficult choices that I face, I have realized that I am not alone in this regard, and that even amongst my immediate peers this problem is very real. Worldwide, many musicians are struggling with the realities of injuries that might disrupt or even wreck very promising professional careers.

The focus of this study is to investigate the occupational and psychological impact of injuries affecting musicians, rather than to concentrate on the physical problems from a medical point of view. It will also explore how these injuries could affect the mental and emotional health of the affected musicians. For this purpose a recognized theoretical model, the Model of Human Occupation, (Kielhofner, 1985) will be used.

In order to become a successful performing artist, a musician undergoes intense development of listening skills and of four functions: thinking, feeling, intuition, and sensation (Ryce - Menuhin, 1992). Besides the technical ability and theoretical knowledge that are absolute necessities, it is the emotional depth and understanding of the music that make an artistic interpretation. Giving a performance can be compared with giving the audience a window with which to look into the performer's soul. For the performer it is an intensely personal experience, and one that places him/her in a very vulnerable position. Often it is also a great emotional outlet for the musician, and sometimes an irreplaceable one. It can therefore be assumed that many musicians are

dependent on their ability to perform in order to assure and maintain emotional well-being.

## **1.2 Rationale**

To my knowledge the occupational and psychological impact of wrist and hand injuries on musicians have not been investigated fully. This ongoing problem is being ignored or avoided and this is resulting in damage to the physical as well as mental and emotional health of students and professional musicians worldwide. I have realized that my wrist injuries had a far greater influence on my life and future career than only the physical and medical components there of, and after having rejected the medical model, I have encountered a theory used by occupational therapists which emphasizes the occupational dilemmas of people. This will be focus of my research.

The Model of Human Occupation (Kielhofner, 1985) is a theoretical model in the field of occupational therapy, which sees occupational injury or disability not as an isolated medical phenomenon, but as a problem with social dimensions as well. By analysing a person's volition, environment and roles in society, one can understand the impact of the injury on a person's life as a whole, and not merely on their occupational life.

In the context of this study, the Model of Human Occupation (Kielhofner, 1985) seems an appropriate model, as many musicians consider the disabling effects of injuries as something that can potentially destroy their hopes, dreams, and future careers.

I hope that this research will contribute to the future occupational well-being of fellow musicians, because of the difference it could potentially make if the dilemmas of injured musicians are recognized and treated holistically.

### 1.3 Methodology

Qualitative research methods are selected when the emphasis of study is on the quality of life and lived experience of an individual, as opposed to the use of quantitative methods using statistical analysis when researching for instance the frequency or incidence of injuries. In this study, a wrist and hand injury is not approached only from a medical point of view, but from the point of view of the effects of the injury on the emotional and mental well-being and the occupational dilemmas resulting from the injury, in order to establish the occupational dysfunction.

Qualitative research will be used to discuss the gathered data. In qualitative research, the world is studied from the perspective of the study participant, and not the researcher (Donholdt 1993 in Carpenter & Hammell, 1999:108)

*Qualitative researchers study things in their natural settings, attempting to make sense of or interpret phenomena in terms of the meanings people bring to them (Denzin & Lincoln, 1994:2 in Cook, 2001:3).*

The result is that qualitative researchers begin their research with a hunch or with certain ideas that may prove important in understanding the research, rather than with a hypothesis developed by the researcher as used in quantitative research (Carpenter and Hammell, 1999:108).

The particular qualitative research method used is a focus group. Focus groups as a research method is frequently used by social scientists when the emphasis of their research is how people experienced certain incidents, or are considering differences and similarities in perspectives (Krueger & Casey, 2002). The number of participants in the focus group can vary from three to ten (Cook, 2001:76). In Cook (2001:76-77), Merton et al (1990) suggest that the effectiveness of a focus group can be measured by four broad criteria, including using the biggest possible range of relevant topics; helping group interaction in order to explore feelings in depth; being as specific as possible with providing data; and taking the participant's personal context into account when analyzing their responses to topics. During the focus group, one central

topic is examined by asking questions in a variety of ways in order to gather deep information:

*...the kinds of questions asked and the ways they are structured provide a frame within which participants shape their accounts of their experience”(Denzin & Lincoln, 1998:167).*

In my study, the participants in the focus group will discuss the effects of the injuries on their lives with specific emphasis on their occupation as musicians.

Many musicians do not realize that they do not have to deal with the effects of their injuries alone. In fact, from my own experience I know that many musicians blame themselves for obtaining the injuries, thinking that they could have prevented it. This can place tremendous emotional stress on a person, who should not have to deal with it without the necessary support. Only an individual who is fully aware of the occupational dilemma of the patient can provide this specialized support, and this is why this research would fulfil a very important role in the education about this common, but very much neglected problem. How can people be made aware of the difficulties encountered by musicians who have experienced injuries, which are now affecting their ability to perform, so that these musicians can enjoy the correct treatment in order for them to adapt under their new circumstances?

In the following chapters this problem will be discussed, and with the use of a focus group and the application of the model of human occupation, the difficulties faced by these musicians will be investigated and analysed.

#### **1.4 Aim of the study**

The aim of the study is to explore the experiences of a group of musicians who became injured to the extent that it interfered with their ability to play their musical instruments, with the purpose of uncovering how the injury influenced their lives as musicians.

## Chapter Two

### Literature Review

In this chapter I discuss literature on the theoretical framework of occupation and occupational science, occupation, narrative and qualitative methods, the Model of Human Occupation, performance arts medicine and alternatives to the medical model

#### 2.1 Occupation and Occupational Science

Occupational science is a science that focuses on occupation, and is an emerging science in the profession of occupational therapy. Occupation is central to humankind as well as to the occupational therapy profession. In order for people with disability to reconnect to their proper place in the culture, Yerxa (1993:3) asserts that occupational science is needed (Yerxa, Clark, Frank, Jackson, Parham, Pierce, Stein & Zemke, 1990:14). Occupational science is not constrained by a positivistic view, and thus is not developing as a science in the traditional sense of the word.

Yerxa (1993:5) defines occupational science as “the study of the human as an occupational being”. Occupation is the central concept around which this study revolves. According to Yerxa (1993:8), the deepest questions concerning human beings as actors, who adapt to the challenges of their environments, using the skills and capacities categorized as occupation, can be pursued by this basic science. It is important to realize that occupational science is not just another model of occupational therapy practice or a practice theory. It offers an integrated conceptual framework, from which multiple and different models of occupational therapy practice may be generated.

Occupation is the central concept in occupational therapy. Derived from the Latin root “occupatio” which means to seize or to take control, occupations are units of activity, classified by the culture (Yerxa et al, 1990:5), according to the purposes they serve in enabling people to live up to environmental challenges successfully. Yerxa (1993:5) describes the essential characteristics of occupation as “self-initiated, goal-directed, experiential as well as behavioural, socially valued or recognized, constituted of adaptive skills or repertoires, organized, essential to the quality of life, possesses the capacity to influence health”.

Occupation is a multidimensional phenomenon, (Christiansen, 1994:3) and includes playful and productive activities, and how these are organised over a person’s entire lifespan, from the play of a child and continuing through the work of an adult (Yerxa, 1990:6). Humans have a biologically driven need to act in the environment, and are most true to their humanity while engaged in occupation (Yerxa, 1993:6). They need to satisfy curiosity by exploring, creating and achieving, and also to demonstrate competency. The daily lives of most people are lived in a physical as well as social environment, which provides physical, psychological, social, cultural, and spiritual demands as well as resources. The interaction between a person and his or her particular context is a requirement of occupation.

Occupation can be divided into five main ideas: rules, habits, skills, flow, and meaning, which could be called the building blocks of occupational science (Yerxa et al, 1990:7; Christiansen, 1994:7; Yerxa, 1993:7).

- **Rules:** Rules guide action with people, objects, and motion, and also reflect social conventions and expectations.
- **Habits:** Habits are performed with little or no conscious thought, and are automatic, reutilised sequences of behaviour.
- **Skill:** The ability of a person to construct an activity pattern through appropriate sequencing of a set of subroutines to match a certain model is

called skill. Skill is an essential capacity of human beings and a vital component of occupation. (Yerxa, 1993:7) For example: "... preparing a meal requires the smooth sequencing of the subroutines of shopping, measuring, mixing, cooking, timing, and serving.. " (Yerxa et al, 1990:9). People do not only need to have learned skills in order to feel satisfied and be competent, but they also need to perceive themselves as skilled or capable of meeting the challenge of the activity. This is often described by occupational therapists as "intrinsic motivation", and may be related to both skill and the perception of oneself as skilled and competent. The way a person perceives his or her skill to meet the challenge of an occupation may lead to such emotional states as boredom, anxiety, or even a "flow state" while engaged in occupation (Yerxa, 1993:7).

- **Flow:** When an individual is faced with a challenge where there is a perfect balance between self-perceived degree of environmental challenge and the individual's skill, a state of "flow" may be entered, where a person can literally lose themselves in an occupation such as playing a challenging piece of music. In Yerxa (1993:39), Csikszentmihalyi (1975) defines flow as something that may occur during engagement in occupations categorised as work, play or leisure, and is very satisfying, life-affirming, and connected to intrinsic motivation and the sense of efficacy. No matter what the activity is, it will always be most enjoyable when a person is able to meet a complex opportunity for action. In fact, flow is so enjoyable, that one would always want to repeat whatever activity has produced it. We seem to experience a rare state of consciousness when challenges are high and personal skills are used to the utmost, and attention is being narrowed down on a clearly defined goal. We also become lost in the activity, and forget ourselves in the process, not worrying about temporary irrelevant issues, and through this expanding the boundaries of the self. The awareness of time also disappears (Csikszentmihalyi, 1993:39). "The idea of 'flow' also might explain why almost no one likes to do housework. Though essential, it presents little or no challenge to one's skills. Thus its rewards, if any,

emanate from other sources such as meeting social expectations” (Yerxa et al, 1990:9).

Flow has many important long-term effects, and does not just improve the quality of experience momentarily. It influences self-esteem and even stress-related illness. This is another reason why injuries have such devastating effects on musicians. The moment an injury occurs, the state of flow is interrupted, and for an artist this may potentially have tragic effects.

- **Meaning of occupation:** Only if one comprehends the experience of engagement in occupation, can occupation be fully understood. It is, after all, the individual who must perceive the degree of environmental challenge he or she is faced with, and who knows what amount of skill he or she possesses. The same occupation can have a variety of different meanings depending on the environmental context, the individual’s goal or mood. Meaning or lack of meaning can also be attached to occupations, as well as symbolic importance, depending on the individual. Occupation is highly individualized. “Occupation provides a source of meaning at the higher levels of the human system. What a person chooses to do with his or her time has social, symbolic, cultural and spiritual significance” (Yerxa et al, 1990:10).

Christiansen (1994:7) believes that occupation is necessary for the adaptation and survival of human beings. It provides a mechanism for learning, and a daily source of amusement and self-maintenance. If viewed over a longer period of time, a human being will also gain a sense of satisfaction and fulfilment.

No action is totally arbitrary or isolated. Because of our past and conditioning, even the smallest experience will fit into a greater structure of meaning. Of all the actions that each individual could choose, their ultimate choice of action would automatically correlate with their sense of meaning (Christiansen, 1994:5-9).

## 2.2. Occupation, narrative and qualitative methods

For many years, narrative has been the main channel through which the human being's thoughts and actions could be understood. It is the structure that organizes the meaning of behaviour in a person's life, just as personality is the structure that attempts to describe how a person's actions are influenced and how behaviour is exhibited (Christiansen, 1994:9).

In occupational science, contribution to knowledge is based on qualitative research methods, narrative data, as well as the telling of stories. A research strategy that probes symbolic meaning to gather narratives should be used. In such cases the methodology can generate knowledge by revealing the storied nature of occupation, where the richness would have disappeared if quantified. Forms of inquiry that are based on narrative and story telling, and are nonmathematical and subjective, are very suitable for occupational science. Yerxa believes that, because of the occupation's richness in symbolic meaning and the science's ethical roots in occupational therapy, subjective, qualitative approaches to inquiry are more suited than experimental methods for the study of occupation (Zemke & Clarke, 1996:vii).

The techniques of occupational storytelling and occupational story-making are based on a grounded theory that includes collaboration, development of empathy, listening and reflecting. In "collaborating" with a patient, the therapist usually works together with the patient as equals. The result is that the therapist does not control the discourse any longer, and the patient assumes an equal status to the therapist. Through this technique, both patient and therapist can learn from each other and their interaction would be equally beneficial.

The second technique is often referred to as "developing empathy", in which the therapist experiences the world of the patient as closely as possible. This often involves self-disclosure by the therapist, such as confessions about personal problems that relates to those of the patient. Through much effort, risk and work the therapist

can then attempt to feel what the patient is feeling, and thus show real and believable empathy.

“Listening” or “being open to others in a caring exchange” is another one of the essential building blocks in creating a communal horizon of understanding. By actively listening with attentiveness, appreciation, and even delight, the therapist makes the patient aware of the fact that someone is really interested in his/her stories.

The last technique in building a common horizon of understanding between therapist and patient is referred to as “reflection”. The therapist would make certain that the patient was correctly understood by verbally reflecting on past conversations and statements.

### **2.3. The Model of Human Occupation:**

Kielhofner (1985) developed a model to describe occupational dysfunction called the Model of Human Occupation. It is one model that can be used to understand the difficulties encountered by musicians who have had experiences of injuries affecting their ability to perform. Kielhofner (1997:103-110) proposes this model, which is concerned with a broader range of phenomena than most other models. This model was chosen because, unlike most models, it is specifically intended for use by any person experiencing occupational dysfunction.

According to the model, Kielhofner describes the human as a dynamic system comprising of three subsystems - volition, habituation, and mind-brain-body performance. The function of these subsystems is to motivate, organize, and make possible performance of occupation. Through the interaction between these subsystems and the environment, occupational behaviour emerges (Kielhofner, 1997:188).

- **Volition:**

Volition arises from the need for action, and occurs when the human being anticipates, chooses, experiences, and interprets occupational behaviour (Kielhofner, 1997:188).

This subsystem can also be subdivided into three parts - personal causation, values and interests (Kielhofner & Forsyth, 1997:60). Personal causation refers to a person's feelings and experiences that can reveal whether or not that person is able to perform certain tasks, and also has an effect on how certain tasks are approached. Values refer to a human's need to try and make sense out of life - a combination of upbringing, morals, and a set of convictions that assign significance or standards to occupation, creating a strong disposition to perform accordingly. Interests influence your choice of occupation, and also refer to individual taste. Impairments may threaten and alter previously positive volition and can lead to a downward spiral into helplessness and demoralization (Kielhofner, 1985).

“When we make occupational choices we are, in effect, selecting a continuation of a story in which we see ourselves. Each person's volitional story reflects a unique and personal journey with its own challenges and accomplishments. Woven into these stories are each person's values, personal causation and interests” (Kielhofner, 1997:103-104).

- **Habituation:**

Habituation can be divided into two parts: habits and roles. Habits refer to tendencies acquired through previous repetition, and mainly operate at a pre-conscious level. Habits are influenced by a wide range of behavioural patterns, which in turn responds to familiar habitats. Experience teaches us rules that serve like a map - this map gives us a way to help make sense of the external world, and help us to locate ourselves and steer our behaviour in unfolding events. This map is called the habit map (Kielhofner & Forsyth, 1997:106).

*... the concept of a habit map is used to refer to an internalised appreciative capacity that allows one to recognize familiar events and contexts, and to*

*construct action for accomplishing a process or reaching a goal* (Kielhofner, 1997:193).

Roles are guidelines as to who a person is in a certain context, and each role has specific rules of behaviour, in other words acting as students, parents, and so on. The identity of a person is shaped by his/her role. The expectations for certain kinds of occupational performance are created by the roles one inhabits. For example, the musician role requires one to do a certain amount of performing in public and spending time playing and practicing your instrument (Kielhofner, 1997:194). Thus, roles place expectations on people, but also create structure and stability. Occupational behaviour is organized by roles in three ways: our manner and style are influenced, as well as the content of our interactions with others; the sets of tasks or performances that become part of our role-related routine are influenced; our daily and weekly cycles are partitioned into times when we ordinarily inhabit certain roles (Kielhofner & Forsyth, 1997:107). Habits and roles are interwoven into our daily lives and helps to construct our behaviour.

- **Mind-and-Body Performance:**

The mind-and-body performance subsystem refers to the spontaneous organisation of actions necessary to accomplish a certain occupation. The body performance subsystem comprises of a complex interplay of musculoskeletal, neurological, perceptual, and cognitive phenomena, and together with the heart-and-respiratory function functions as a whole, which makes up the body component of the subsystem. The mind component is made up of symbolic images, and guides the system in the planning, interpretation and production of behaviour (Kielhofner & Forsyth, 1997:107).

Effective occupational performance can only be achieved when all of the constituents of the mind-brain-body performance subsystem work in collaboration with unfolding circumstances and environmental conditions (Kielhofner & Forsyth, 1997:107). Disabilities may occur when there are disturbances to the neurological, musculoskeletal, and symbolic constituents of the mind-brain-body performance subsystem (Kielhofner, 1997:199). The

Model of Human Occupation emphasizes the importance of understanding the performance subsystem, and calls attention to experiences of restrictions in motor capacity, sensation, perception, or cognition.

- **Environment:**

The environment is another very important aspect in occupational behaviour. In occupational behaviour the environment has two broad influences. Firstly, the environment creates opportunities for performance. Environments represent specific potentials to which humans may respond, and thus afford a wide range of opportunities for occupational behaviour. Secondly, the environment 'presses' for certain types of behaviour, which refers to what the individual perceives to be the expectations and demands of the environment (Kielhofner & Forsyth, 1997:108). We can for instance feel pressure from what others expects from us. Each environment both affords opportunities and presses for certain occupational behaviour, and because of this they influence behaviour. The environment can be thought of as having both physical dimensions (space and objects) as well as social dimensions (people). In the social environment certain roles are created, for instance being a student, and it also includes the groups of people that we join, and the occupational forms that these people perform (Kielhofner & Forsyth, 1997:108).

Occupational dysfunction can be greatly affected by the physical and social environment. Occupational forms may be made impossible or may have to be altered as a result of impairments, and occupations that were once easy everyday affairs may suddenly require assistance from others and take a great amount of time (Kielhofner, 1997:199).

The above overview of current theoretical arguments in the Model of Human Occupation can provide a means of understanding how human occupation is motivated, organised, performed, and influenced by the environment.

## 2.4. Occupational Dysfunction:

According to the World Health Organization or WHO (International Classification of Functioning Disability and Health, 2001), dysfunction or disability is an umbrella term for impairments, activity limitations, and participation restrictions. It denotes the negative aspects of the interaction between the individual (with a health condition) and that individual's contextual factors (environmental and personal factors). In occupational science, occupation is defined as chunks of daily activity that can be named in the lexicon of the culture. A person's occupational history shapes, to some extent, what he/she will become in the future (Zemke & Clarke, 1996:vii). In Zemke and Clarke's view, if disease or disability strikes, individuals will be able to reconstruct meaningful lives, drawing on threads of their past selves to create a sense of continuity in their new situation (Zemke & Clarke, 1996:vii). One way of achieving this is through commitment to action, in other words, occupation.

According to Kielhofner (1997:104), occupational dysfunction is not merely a state, but could rather be described as an ongoing process in which unfolding occupational behaviour as well as experiences contribute to difficulties an individual could experience. Within this process disability can be maintained, worsened, or ameliorated. To understand occupational dysfunction, one cannot rely on generalizations as there is no relationship between the degree of physical impairment and the degree of maladjustment the individual exhibits.

The knowledge that one is less capable than others, or than one used to be, can be a source of considerable psychic pain and social embarrassment. For this reason some persons will go out of their way to avoid situations that provide occasions for failure (Kielhofner, 1985:159).

The function of volition is the ability to be able to make one's own choices. Whatever its contribution to occupational dysfunction, volition is likely to be a strong influence on any process of adjusting to or overcoming the challenges of a disability.

Both knowledge of capacity and sense of efficacy can be affected when a level of impaired capacity is experienced. The extent of the incapability directly influences the implications on personal causation and its impact on one's lifestyle. Individuals are often confronted with experiences that challenge and even contradict their view of themselves as competent as a result of physical dysfunction. Physical impairments often mean that a person achieves less than others or less than they desire (Kielhofner, 1985:162). An extreme sense of efficacy may extinguish any internal desire for accomplishment.

The way in which we experience disability when it comes into our lives may be greatly defined by our values. "Disability imposes a discontinuity between what one can do and what one values or believes one should do. This results in a low self-esteem or painful alienation of values." (Kielhofner, 1985:164) This may be true especially for persons whose previous occupation included substantial physical ability. This can mean either rejecting old values or devaluing one's self as unable to live up to old values. One's circumstances can drastically be altered by disability, which can challenge the whole view of life in which one's values are embedded. A disability experience may radically change one's existence, and could force a one to rethink one's values and one's fundamental view of life. The consequences of role-loss can be severe. The cost to personal identity is quite severe when a person is no longer recognized as the musician or artist that they used to be or want to be (Kielhofner, 1985:171).

Loss of capacity can result in the devastation or elimination of whole routines of living and ways of thinking. The determination of whether, and in what ways, a person's occupational life may be said to be dysfunctional, may often be the largest challenge. For example: Occupational dysfunction is recognised when a person does not use their capacities in a reasonable way to respond to reasonable expectations of the social collective. Occupational dysfunction is also recognised when a person's occupational life promises to negatively affect the integrity of the human system. It is of great importance to understand which components of the human system, as well as the environment, are most significantly contributing to the occupational dysfunction. Careful examination of, and consultation with the individual in question is the only answer (Kielhofner, 1985:173).

## 2.5. Performing Arts Medicine:

Performing arts medicine is a new medical field and has been developed over the past fifteen years. The main focus is to serve the needs of performers and to treat their injuries and illnesses, equivalent to an athlete's sports medicine. Music teachers and musicians are increasingly becoming more aware of the fact that playing a musical instrument can result in a variety of different aches and pains. There are, however, still an alarming number of musicians who do not realize the importance of being aware of the range of these injuries, either in terms of frequency or severity. "Some instrumentalists choose to ignore their injuries because they feel responsible for their symptoms" (Allen, 1996:2).

When performers place abnormal stress on their musculoskeletal systems, performance-related injuries occur, which includes muscle spasms, tendonitis, nerve impingements, and carpal-tunnel syndrome. These injuries can be a result of several factors, including misuse, overuse, and the repetitive stress associated with prolonged practice. These factors can potentially be aggravated even more by a faulty technique, poor physical condition, stressful postural positioning, and extreme schedules. By using a few preventive techniques the risk of injury can be decreased, although there is no guarantee that performance-related injuries can be avoided (Allen, 1996:2). This is why it is of such importance that injury education be included in the training of musicians.

It is of the utmost importance that there should remain a healthy balance between performance, exercise, diet, and sleep, which will strengthen resistance to performance-related injuries. It is said that some musicians take better care of their instruments than of themselves (Allen, 1996:3)

## 2.6. Alternatives to the Medical Model:

In occupational therapy, one of the models of viewing the effects of disability, injury or impairment in people's lives is the bio-psychosocial model. A variety of conceptual models have been proposed to understand and explain disability and functioning. The "medical" model views disability as a problem of the person, directly caused by disease, trauma or other health condition, which requires medical treatment by a professional, in the form of individual treatment. Management is aimed at cure or the individual's adjustment and behaviour change.

"The 'medical model' regards disability as an individual's impaired condition, treats it as a disease state requiring intervention/cure, and privileges the knowledge, skills, and even the power of health care personnel and other clinicians in the fields such as social work and special education" (Lubet, 2002:59).

In contrast to the medical model, the "social" model sees issues mainly as a socially created problem, and basically as a matter of the full integration of individuals into the society. Disability is not an attribute of the individual, but rather a complex collection of conditions, many of which are created by the social environment. Management of the problem requires social attention (World Health Organization, 1996:18-20).

Alternative health models, including natural medicine, complimentary medicine and alternative healing methods are rapidly gaining popularity in the Western World.

Homeopathy is the second most widely used system of medicine in the world. It is extremely effective, and with the correct remedy results can be swift and permanent. Homeopathy as well as antroposothical medicines are completely safe and can usually be taken alongside other medication without the fear of having side-effects. Another advantage of choosing homeopathic medicines is that it is not addictive, and that it is holistic, meaning that it addresses the cause of the problems, and not the symptoms. This often means that the symptoms do not recur ([www.homeopathy.com](http://www.homeopathy.com)).

## **2.7 Autobiographical account of my experience:**

Having been an active and successful musician since the age of eight, I had the realistic dream of becoming a professional musician, and having the career choice of being a performing artist. I never had any doubts that this dream would be realized, and experienced other activities, like school, as a mere distraction from what I was really concentrating on. Needless to say, not much time was spent on developing other skills or talents. I made the decision to finish school through a correspondence course, in order to be free to dedicate my time to music. This was a big step taken with a lot of conviction.

I experienced pain in my wrist for the first time in the winter of 1999, at the age of nineteen. At first, as with so many musicians, I chose to ignore the problem, feeling responsible for my injuries. This, of course, was a very bad decision as it aggravated the problem, which eventually started to affect not only my practising, but also my everyday activities. I then notified my lecturer, who could not give me adequate guidance on the matter. This was followed by numerous visits to orthopedic surgeons, specializing in hand and wrist surgery. However, the problem was misdiagnosed and I was given incorrect advice which wasted valuable time.

At first, the problem was diagnosed as tendonitis, which is commonly associated with overuse of a joint, for instance, an ankle or elbow, or in my case a wrist. I was advised to completely refrain from practising until the pain had disappeared, and also had to wear a very uncomfortable, as well as unsightly, wrist support that reached up to my elbow. The combination of the pain in my wrists and the wrist support turned everyday activities into a huge struggle- brushing my teeth and bringing a coffee mug to my mouth became difficult. After months of struggle, it became clear to me that the doctor's advice was in fact worthless. In 1999, my injury was diagnosed as carpal-tunnel syndrome, and I received surgery to my left wrist, with which the surgeon attempted to free the tendon by making a cut through the tunnel through which the tendon has to move, and therefore creating more space and freedom of movement inside the tunnel. The diagnosis was correct, but the treatment was not. This became clear when the same symptoms recurred shortly after the operation.

The next step was to find another hand specialist, this time someone who had previously worked with musicians, and in particular pianists. The doctor expressed his disapproval about the manner in which the previous doctor had operated, and assured me that I was now in good hands. By that time I was becoming more anxious by the day, and was thankful when the doctor suggested that surgery was the only answer for my problem. This was in the year 2000, approximately one year after the first surgery was performed on my hand. The surgery was to my right wrist, and of the same nature as the first surgery to my left wrist. It was very painful. Although I was assured that I would be able to resume my practising within ten days of the operation, I was still in considerable pain months afterwards. This was very troubling indeed, seeing that I was in far more pain after the operation than before.

Desperate, I consulted yet another hand specialist (February of 2001), who also chose surgery as the best option. I received surgery to both my wrists, which were of the same nature as the previous operations. Being less painful than the previous operation, I was hopeful that it would be successful, and that I was finally on my way to recovery. I could even resume my practicing, but only a few weeks of playing triggered the same pain as before. I was devastated, as I could not again afford to stop practicing and suppressed the pain with cortisone injections in my wrists (Spring of 2002) as prescribed by the same doctor who had performed the last two operations. But I became convinced that this was a very unsatisfactory and short-term solution. My only hope was to find yet another hand specialist. The same type of surgery was repeated on both my wrists, leaving me unable to care for myself for two weeks. This meant depending on others for feeding and cleansing. I was desperate to recover, which was the only way to keep a positive frame of mind through this humiliating ordeal. More than a year after the last operations, in other words in the beginning of the winter of 2003, I still experienced the same symptoms as before. I was disillusioned with the medical profession, and now turned to rhythmical massage therapy and anthroposophic medicines to enable me to pursue my career as a musician. These experiences left me emotionally drained and still in pain after four unsuccessful operations on my wrists. But not being able to practice my instrument was causing me indescribable anxiety and stress, especially as it seemed that the medical profession had failed to deal with this problem. I discovered an alternative

route via massage therapy and anthroposophic doctors, who not only dealt with the specific area of the body where the problem occurred, but with the body as an intrinsic entity.

The rhythmical massage therapist diagnosed my injury as carpal-tunnel syndrome, but also diagnosed poor blood circulation caused by a damaged liver, mainly as a result of medication I had used previously. This was causing blockages in the areas around my joints, resulting in pain. Another factor contributing to these blockages was a slow metabolism, caused by an inactive thyroid gland. In addition to the rhythmical massage therapy, homeopathic medicines were prescribed for the liver and thyroid gland. I was also made aware of some food intolerances, which contributed to a slow metabolism. These treatments, combined with regular exercise, enabled me to resume my studies without further interruption.

While gaining knowledge about occupational therapy, I realized what an important role occupation plays in our lives, and also how important it is for our sense of well-being. The problem that I have been facing for so many years, along with many other musicians worldwide, is one of an occupational nature.

## **Chapter Three**

### **Methodology and Application**

In this chapter I discuss the theoretical constructs of the methodology of the study and I describe the research methods used in my study.

#### **3. Qualitative research:**

##### **3.1 Qualitative vs. Quantitative Research**

It is important to differentiate the language of qualitative research from that of quantitative research. Quantitative methods attempt to screen interpretation, and try to produce a clear and uninfluenced representation of the object of study. Many qualitative researchers would argue that this is impossible because our representations of the world are always influenced by interpretation. (Banister, Burman, Parker, Taylor, and Tindall, 1994:2) It is in the nature of interpretation to be contradictory, and having multiple ways of meaning. Thus, we cannot limit or control the data.

##### **3.1.1. Definition of qualitative research**

Lincoln & Guba (1985) state that: "One of the main principles of qualitative study is that 'realities are multiple, constructed and holistic'"(Lincoln & Guba, 1985:37 in Cook, 2001:5). According to Cresswell (1998:15) qualitative research explores a social or human problem using very specific methodological traditions of inquiry. The function of the researcher is to build an intricate holistic picture, to analyse words, report the information gathered from the informants and to conduct the study in a natural setting.

### **3.1.2. What is qualitative research?**

In qualitative research there is being attempted to interpret phenomena “in terms of the meaning people bring to them”(Cook, 2001:3). It works from the standpoint that, to fully understand human behaviour, the importance of the person’s perspective and meanings attached to actions must be valued. According to Asbury (1995) qualitative data should not be treated in the same way as quantitative data, in other words, it should not be tallied, counted, or taken out of context (Cook, 2001:80).

### **3.1.3. Relevance of qualitative research to this study**

In contrast to quantitative research, where the behaviour of abstract populations are predicted, qualitative research aims to get a greater understanding of the phenomena. Qualitative researchers believe that they are often the students, and that the individual has the knowledge of the phenomena of the present study. “Qualitative inquiry also acknowledges the participants in research studies as the experts, having the right to share in research endeavours and their results” (Cook, 2001:8).

## **3.2. Research methods: Focus groups**

### **3.2.1. Definition of focus groups**

A broad definition has been given by Morgan (in Cook, 2001) who defines focus groups as a “research technique that collects data through group interaction on a topic determined by the researcher.” Wilkenson (in Cook, 2001) describes focus groups as a specific topic being discussed informally by selected individuals. A detailed definition is given by Carey and Smith (1994:124), which states that a focus group is a way of collecting information about a specific topic using a semi-structured group session in an informal environment. Asbury’s (1995:414) definition adds another dimension: “a data collecting technique that capitalizes on the interaction within a group to illicit rich experiential data.” The conclusion can be made that the use of the group approach in this form of data collection can be seen as the unique factor (Cook, 2001:76).

### **3.2.2. Use of focus groups in qualitative research**

Focus groups are one of the most widely used tools of research in social sciences (Stewart, and Shamdani, 1990:52). Over the past ten to fifteen years, social scientists appear to have rediscovered focus groups, which has become an increasingly popular method of gathering qualitative data (Morgan in Cook, 2001). Asbury (1995:419) states in Cook (2001:75)

*to appreciate the potential of focus groups as a social and behavioural science research technique, one must first appreciate the value of qualitative methods in general.*

Focus groups are almost always established with the main purpose of collecting qualitative data. One of the reasons for this is because a very rich amount of data can be expressed in the individual's own words and context (Stewart & Shandani, 1990:12).

### **3.2.3. Use of Autobiographical research in qualitative research**

The inclusion of an autobiographical narrative of my own experience was to help understand and unpack the topic from my own perspective. Autobiographical research is one of the methods of qualitative research (Taylor & Settelmaier, 2004; Oberg, Hasebe-Luat, Leggo, Chambers & Hurren, 2000).

## **3.3 Data gathering**

In my study I am using a focus group as my data gathering tool, interviewing musicians whose lives and careers has been affected by injuries. Through this research method the full range of ideas and feeling that these musicians have about their injuries could be explored. According to Krueger (1994:31) focus group interviews work because they

*tap into human tendencies... they are helpful when insights, perceptions and explanations are more important than actual numbers.*

It is very common for focus groups to be recorded for further analysis. The data, in other words the discussion generated during the focus group, is usually audio-taped. This very seldom interferes with the responses of members in the group. The data is then fully transcribed. Thus the final data is a full transcription of the audio-taped focus group discussion.

### **3.3.1. The interview guide**

An important factor in focus group research is the design of the interview question guide. This will be determining the agenda for discussion in the group and will provide structure within the discussion. A well-designed interview guide will prevent that the focus group turns into an unfocussed general discussion amongst people who happen to be available (Stewart, & Shandani, 1990:11).

According to Stewart & Shandani (1990:52) the interview guide has to be developed in the following way in order for the focus group to be conducted successfully:

- Questions should be asked from the more general to the more specific
- Questions should be placed in order of their relative importance to the research agenda, in other words the questions of the most importance should be placed earlier.
- Questions should be phrased simply in clear, understandable language.

The questions used in my focus group study are as follows:

1. When did your injury first appear?
2. How did this make you feel?

3. What was your initial reaction?
4. How did this injury influence your practice/performing routine?
5. What influence did your injury have on your everyday life?
6. In what way did the injury influence your career choices? Was there possibly a shift in focus?
7. How does this make you feel? To what extent were you affected emotionally? Did the injury have any influence on your self-esteem or feeling of self-worth?
8. How does your future plans differ from those you had before the injury occurred?
9. How do you feel about this?

### **3.4. Participant selection**

In focus groups, clearly identified sets of individuals are used in order to obtain specific types of information. Individuals who have had specific experiences were selected for the focus group, in this case three musicians who had experienced the effects of injuries on their lives. To protect their identities, I will refer to them as A and B, and to myself as C. It can be said that the selection of the members in the group, together with the interview guide, works together as the research instrument (Stewart & Shamdani, 1990:52).

#### **3.4.1. Criteria for selecting participants**

A purposive sample of information rich individuals (Krueger and Casey, 2002) will be used. Individuals participating in a focus group must be able to represent the population of interest and must be willing to share the desired information with the

rest of the group. According to Cook (2001:77) it is preferable to use strangers as the participants in a focus group, but due to practical considerations not always possible.

*The question of whether participants should be strangers or acquaintances speaks to issues regarding what people will discuss or not discuss in the presence of strangers or with whom they may have already erected invisible boundaries and understandings around some topics (Cook, 2001:77).*

Thus, group members should be chosen with careful attention and their possible effect on the research objectives should be considered. The term segmentation is used to describe the careful choosing of group participants.

When the behaviour of groups and the interaction among group members are considered, it is important to remember that it is the characteristics of group members relative to one another that ultimately determines the group performance, and not merely individuals in the group. Big age and personality differences can play a role in group dynamics, as well as emotional stability of group members such as control, anxiety, defensiveness, and depressive tendencies (Stewart & Shamdani, 1990: 33).

The participants selected for this focus group are talented musicians with potentially bright futures in music, but challenged by the difficulties connected to injuries, both physically and psychologically.

### **3.4.2. Number of participants**

The size of a focus group is an important factor to consider. The size of the focus can vary, but Cook (2001:79) narrows the ideal number of participants to between six and ten. There are certain disadvantages to both small and large groups. In small groups there may not be sufficient contrast in opinion, while big groups might inhibit some of the more introvert members from sharing their opinions.

For my study, I selected and obtained consent from six participants, but only two complied and turned up for the focus group. My own participation was deliberate as I used my own experience reflectively. This is inline with the reflective nature of qualitative research in which narrative and autobiographical accounts are used to develop deeper understanding.

### **3.5. Data analysis**

Interpretation and analysis of information is the most rewarding, but also the hardest part of focus group research, and already begins during the focus group session. After the session analysis continues through the review of the objectives of the study, and of the process, analysis of the recordings and discussing the session with any observers (Cook, 2001:79).

An important aspect of focus group analysis is commenting on the group interaction, and also the impact of the setting. Interestingly enough, many researchers fail to report on this very integral part of focus group research, which might be seen as defeating the purpose of the focus group research method.

According to Carey and Smith (1994) there are three levels on which data should be analysed: on group level, individual level, and at the level of comparing individual data with group data. An ability to organize large amounts of data into categories, to recognize the key themes in the data, and to find a useful way in which to report positive and negative findings are other essential skills needed for the reporting of qualitative data (Cook, 2001:79-80).

The qualitative analysis methods used in focus group research are in complete contrast with quantitative studies, where there is a clear separation between data collection and analysis. Focus group analysis already begins with the focus group. The focus group interview is audio-taped and has to be transcribed. To make the analysis process simpler, data is coded and placed together under certain categories (Krueger & Casey, 2002:128-144).

According to Krueger and Casey (2002:128) focus group analysis is systematic and deliberate, and not spontaneous or arbitrary. This will ensure that the focus group results reflect the shared feeling in the group, and that no important data is being overlooked. The analysis strategy has to be documented and understood by the researcher.

*Another researcher should be able to arrive at similar conclusions using the available documents and the data (Krueger, 2002:128).*

### **3.6. Ethics**

#### **3.6.1. Informed consent**

When the participants for the focus group are recruited, it is the duty of the researcher to insure that the individuals know exactly what the research is for, and that any information given by the individuals may be quoted as part of the research project. For my study, each of the participants in my focus group was informed exactly what this research entails, and that the information given by them could be used as part of my research, or even quoted in the research. I was fortunate to have chosen participants who were very willing to share their experiences in order to potentially save other musicians from undergoing a similar ordeal.

#### **3.6.2. Confidentiality**

It is important that group members be put at ease by the knowledge that, under no circumstances, any of their names will be disclosed in the research project. This will ensure that members of the focus group will have the peace of mind to be able to speak freely, without having to worry about personal information being published.

#### **3.6.3. Triangulation**

Different data sources must be triangulated by re-examining data retrieved from literature, experiences with peers and own experiences, and only then reaching a final conclusion.

*Triangulate different data sources of information by examining evidence from the sources and using it to build a coherent justification for themes (Creswell, 2003:196).*

### **3.6.4. Member checking**

According to Creswell (2003) accuracy of the qualitative findings can be determined by taking the final report back to the individuals in the focus group, and ensuring that the true experiences of these individuals are being reflected.

*The establishment of the trustworthiness (Lincoln & Guba in Cook, 2001) of qualitative research is partially dependent on member checking with one's informants to ensure that the interpretations of their experiences reflect their perspective (Cook, 2001:8).*

Interpretations we make are often highlighted or corrected with this method, and it ensures that it is not our own subjective perspectives that are being presented.

### **3.7. Data gathering and analysis of this study**

I selected four participants for the focus group but only three participated. I was one of the participants. I explained my research, introduced the topic, and asked for informed consent. The room was quiet and secure, and the environment was familiar to all of the participants. Two tape recorders were used to record the focus group discussion, which lasted for approximately fifty minutes. At that point I felt that I had gathered sufficient data for my research.

The participants, comprising of two males and a female, were respectively twenty-four, twenty-five and twenty-six years of age. Participant A is a viola player and participants B and C are both pianists. All three of the participants have undergone extensive musical training since an early age, and have excelled in their respective instruments. In all three cases, the injuries were caused mainly as a result of overuse and an unbalanced lifestyle. Participant B's injuries were diagnosed as tendonitis, and participants A and C were both diagnosed as carpal-tunnel syndrome.

I analysed the data by fully transcribing the tape recording, and coded all the data. Then the data was read for emerging categories. Categories were coded. The matching categories were classed into groups and I derived the underlying themes from each set

of categories. I discussed the data in terms of the themes that emerged from the study, and this is discussed in the following chapter.

### **3.8. Limitations**

As a researcher I realise that the number of three focus group participants is not ideal, and that the information would have been richer, would the focus group discussion have consisted of more participants. The fact that only three out of an ideal number of six participants attended the focus group discussion was unfortunate, but the required aim of gathering adequate data could nevertheless be fulfilled, which allowed the research to be based on the data gathered from this focus group discussion.

University of Cape Town

## Chapter Four

### Results

In this chapter, I report the findings from the analysis of the data. The purpose of the focus group was to explore the participants' experiences and the impact their injuries had on their lives as musicians. Analysis of the data revealed the following themes and categories:

Themes	Categories
<p><b>My injury affected my occupation</b></p>	<ul style="list-style-type: none"> <li>• I was in a great deal of pain</li> <li>• I was practicing 8 hours a day</li> <li>• Wrong diagnosis: Inadequacies of medical model</li> <li>• Disappointment, sadness, fear and loss</li> </ul>
<p><b>I was forced to adapt to an alternative occupation</b></p>	<ul style="list-style-type: none"> <li>• Uncertainty about future</li> <li>• The teacher couldn't help or advise</li> <li>• Change in occupation</li> </ul>

#### 4. Findings from the data

##### 4.1. Theme one: My injury affected my occupation

The theme: *My injury affected my occupation* arose from the following categories:

- I was in a great deal of pain
- I was practicing 8 hours a day
- Wrong diagnosis: Inadequacies of medical model
- Disappointment, sadness, fear and loss

#### 4.1.1. I was in a great deal of pain

When the participants discussed the effects of the injuries on their lives, they described how it affected them at first. One participant said:

*I started having problems when I was in standard seven. It was getting sore in my fore-arms, and also in my left hand. That was the first sign. The first really serious thing was a spasm in my right arm, but I was still playing. When it really hit me was when I played a competition, and in the final round my arm suddenly decided, ok, that's it! I finished the round, but it wasn't very comfortable...I was faced with a very serious problem because it was affecting my right and left hands. It was diagnosed as carpal-tunnel syndrome (Participant A: focus group 23\12\2004).*

All of the participants were taken by surprise by their injuries, and were not prepared to deal with the effects. Participant B experienced dramatic physical effects and was in a great deal of pain after the first occurrence of the injuries.

*I woke up with the injury from one day to another. Suddenly I couldn't roll down my car window. My elbow was so sore...on the inside of the elbow, in the wrists and even in the fingers. So much of the music that, before the injury I knew I could play very well, was just so difficult from a physical point of view after the injury (Participant B: focus group 23\12\2004)*

Participant C experienced the same physical difficulties.

*I had difficulty holding a mug or shaving, and had problems with changing the gears of my car (Participant C: focus group 23\12\2004).*

For participant A the biggest problem lay in the fact that the injuries were affecting his occupation as a musician.

*I would have to practise for a show and it would just be pain (Participant A focus group 23\12\2004).*

Injuries clearly have a great impact on the physical well-being of the musicians, in their occupational as well as their everyday life. This is only one of the many areas in the musicians' lives that were affected by their injuries.

#### 4.1.2. I was practising eight hours a day

With all three of the participants, the factors that contributed to being injured were very similar. A main cause of injury was over-use of the arms and hands, which usually went hand in hand with preparing for a competition or an exam.

*I changed from a violin to a viola and I started practising instead of just playing. I practised hard for a year, and that is when I started having problems. I think I was putting too much pressure on in... it was over-use. It really hit me when I was playing the final round of a competition (Participant A: focus group 23\12\2004).*

Participant B was preparing for a competition and was practising more than usual:

*My injuries also occurred during a competition - the first time that I really started practising. I was preparing for a competition and practising more than usual - a bit obsessive. I did one more hour, and the next day my hand was completely messed-up (Participant B: focus group 23\12\2004).*

Excessive practising also contributed to Participant C's injuries:

*In my second year I was preparing for an exam and started practising eight hours a day. This is when I first started to experience problems in my wrists (Participant C: focus group 23\12\2004).*

It became clear that lack of physical exercise and injuries went hand in hand. A lack of physical activity also contributed to poor blood circulation, which is linked to most cases of carpal-tunnel syndrome.

*When my injuries first occurred, I was practising for a competition and I wasn't being very active (Participant B: focus group 23\12\2004).*

Musicians spend so many hours just sitting, practising their instruments, and not having a balanced lifestyle.

*My injuries were also brought on by a circulation problem. It was in matric and varsity when it started holding me back. I wasn't really doing any exercise when it happened (Participant A: focus group 23\12\2004).*

Not playing with the correct instrument could also contribute to being injured. Participant A was forced to apply excessive pressure on his arms and wrists in order to create the correct sound on his instrument.

*My instrument and bow wasn't very good at that stage - the bow was too light. So I had to apply more pressure, so there was too much strain (Participant A: focus group 23\12\2004).*

Another contributing factor - one that all three of the participants had in common - was changing from one teacher to another. A new teacher would necessarily change

new student's technique to a certain extent, and that could potentially create a lot of stress and tension in the hands, wrists, and arms.

*What I think also contributed was that my new teacher was working a lot on control, and there was a lot of unnecessary tension. And also because she sits very low, and she pushed me in that direction and made me sit very low which caused a lot of stress on the elbow and wrists. The teacher always pushes certain things, sometimes changing your technique. I was very stiff, and my new teacher tried to make me more flexible, and focussed a lot on lateral and circular movements, almost a bit obsessively. I was later told that the micro-movements in the wrists could cause a lot of irritation. Every teacher has got a different technique and that isn't necessarily the right technique for every pupil (Participant B: focus group 23\12\2004).*

Musicians, especially teachers, should be made more aware of how to diagnose and treat injuries. In this way serious injuries could be prevented, which could spare the musicians lot of physical, emotional and psychological stress.

*It's scary to realize how few people knows that it's your whole body or system that is involved in your playing, and not only your hands. My wrist problems have originated in my shoulders being too stiff (Participant C: focus group 23\12\2004).*

After the focus group discussion, it became clear that one of the main causes of the participants' injuries was over-use of the hands, wrists or arms, which usually accompanied preparations for competitions or exams. A lack of physical exercise as well as changing to a new teacher also contributed greatly to being injured.

#### **4.1.3. Wrong diagnosis: Inadequacies of the medical model**

The injuries that were experienced by the focus group participants proved to be difficult to diagnose and also difficult to treat correctly. Misdiagnoses by medical specialists were the cause of much suffering, both mentally and physically. Seeing the natural feelings of fear and doubt in the participating musicians as unnatural psychological occurrences, some medical specialists referred participants to psychologist and a psychiatrist, who did not contribute in any way to their recovery.

During the focus group discussion, the participants described the different kinds of interventions that were attempted in order to get some relief from the suffering caused

by their various injuries. Some were more successful than others. Participant A consulted a medical hand specialist, who was only focussing on short-term solutions.

*In the beginning of 1992 I went to a hand doctor who prescribed cortisone injections (Participant A: focus group 23\12\2004).*

Participant C was feeling disillusioned after consulting various medical hand specialists in order to find the most suitable treatment:

*The hand specialist didn't try to trace the cause of the problem, but was only interested in cutting open where the symptoms were (Participant C: focus group 23\12\2004).*

Participant B chose alternative interventions that were more aimed at long-term solutions to his problems:

*I went to a physiotherapist, and I also started doing yoga - I found that I could practise so much more. I was walking for about an hour a day - I only started doing yoga later, and I found that really helpful. It is also so effective for good circulation to stretch regularly (Participant B: focus group 23\12\2004).*

Before the injuries were diagnosed, participants experienced a wide range of feelings and insecurities. In some cases, teachers or fellow students suspected psychological causes.

Participant B consulted a psychologist in order to know whether the pain that he was experiencing was in fact a result of fear.

*I also went to a shrink, who told me that it was all in my head, and caused by fear (Participant B: focus group 23\12\2004).*

Participant C was also experiencing a great deal of self-doubt, and decided to explore the possibility that the injuries were in fact a way of avoiding the stress and workload associated with the profession:

*I went to a psychiatrist, and didn't gain any valuable knowledge from the visit (Participant C: focus group 23\12\2004).*

Participant C finally discovered that the interventions that best suited her specific problems lay in alternative medicines and a healthy, well-balanced lifestyle. As mentioned earlier in this document, she has discovered an alternative route via

Massage Therapy, which works along the principles of anthroposophy as developed by Rudolf Steiner in the early 1900's. Massage therapy also helped soften scar tissue on her wrists that formed after the operations, which caused discomfort when moving the wrists. Anthroposophic doctors, who not only deal with the area of the body where the problem occurred, but with the human body as an intrinsic whole, also contributed to the recovery. These treatments, combined with regular exercise, enabled her to continue her studies without further interruption. Regular exercise played a vital role in the recovery process, seeing as poor blood circulation and a slow metabolic rate contributed to blockages forming in her wrists, causing a lot of pain.

All three of the focus group participants consulted medical specialists for advice and treatment of their injuries. The prescribed treatments were mostly aimed at relieving the symptoms of the injuries, in other words short-term solutions, and not at treating the problems that were causing the symptoms.

#### **4.1.4. Disappointment, sadness, fear and loss**

The injuries had a severe emotional impact on all three of the participants. The emotions experienced the most by the focus group participants were fear and loss. Feelings of disappointment, sadness, paranoia, self-doubt, and demotivation were also common among the participating musicians.

One of the participants commented about his disappointment:

*It was a setback and I wasn't feeling very happy. I've never experienced anything like this before* (Participant A: focus group 23\12\2004).

Participant B experienced disappointment and a loss of excitement, which caused a dramatic change in his emotional well-being from before the injuries until after the injuries had occurred:

*It was the first time that I really started practicing, and I was really excited. When I was injured, I had to pull out of a competition, and that wasn't easy* (Participant B: focus group 23\12\2004).

The feelings of fear, doubt, paranoia and pressure associated with not knowing exactly what the cause of the injuries were, and how to prevent further injury,

contributed greatly to emotional stress caused by the injuries, including paranoia and doubt, especially when preparing for important events like exams or competitions:

*The biggest problem with having an injury is the fear associated with it, and the paranoia. You never know how much to do, and whether you should work through a certain amount of pain or discomfort, or leave it. There were also exams and competitions coming up (Participant B: focus group 23\12\2004).*

The fear of contributing further to your injury, and being unable to achieve a set goal, were some of the factors that were causing emotional stress. Participant C was experiencing a loss in spontaneity, freshness, motivation, and enthusiasm, as well as feelings of disappointment. Participant C said:

*I felt that it took the spontaneity and freshness out of the playing... after the injuries I was always afraid and I got too scared to practice a lot - and to plan ahead. You are so scared of being disappointed again. It demotivates you, and it puts a damper on the enthusiasm with which you approach your music (Participant C: focus group 23\12\2004).*

During the focus group discussion, the participants discussed the vast psychological impact their injuries had on them. One of the participants' initial reactions was the fear and self-doubt that she was imagining the pain in order to avoid the heavy workload associated with her occupation:

*I was wondering whether it was my mind playing tricks on me - maybe I was really just looking for an excuse not to practice. So many people told me that it was all in my head and that I was just afraid (Participant C: focus group 23\12\2004).*

Participant B had a similar experience, and his teacher was confirming his fear:

*That was another thing that was bothering me - my teacher pressuring me by telling me that it was all in my head and that it was fear, nothing else (Participant B: focus group 23\12\2004).*

Participant A had a similar experience, experiencing a loss of excitement and joy of practising:

*For me the injuries meant that I couldn't get excited about my playing, because you know that somewhere down the line it's going to be sore. It took away the joy of practising... it was like a loss of innocence (Participant A: focus group 23\12\2004).*

The injuries forced Participant A to consider a complete shift of focus of occupation, which affected his happiness and which contributed to a large extent to the emotional stress that he experiences. He experienced a loss in career ideal:

*I have surprisingly been able to play a lot at a professional level, but I cannot see myself playing viola at a very high level in future. That is something that I would have to see, and it's very sad (Participant A: focus group 23\12\2004).*

Participant C also experienced emotional stress after having to adjust her future career plans, forcing her to abandon her first career choice:

*For me, a career as a teacher is very second best and it makes me very sad when I know that I could have been successful with what I was doing (Participant C: focus group 23\12\2004).*

## **4.2 Theme two: I was forced to adapt to an alternative career**

The categories from which the above-mentioned theme arose were:

- Uncertainty about the future
- The teachers couldn't help or advise
- Change in occupation

### **4.2.1 Uncertainty about the future**

Uncertainty about the future was also a big concern among the participants, causing a great deal of psychological stress:

*You want to know whether or not it was going to get better. You can put your energy into something else, but it's always in the back of your mind. It makes you think about taking up other things, and going down other avenues like conducting or something to do with music, but it's difficult to work when you are constantly thinking about other things you can do (Participant B: focus group 23\12\2004).*

Participant C needed the confirmation that the injury was indeed curable in order to feel more confident about her occupational future:

*It's a question of wanting to know whether or not it is going to get better. If it's not then at least I know I should stop what I am doing and pursue something different. This was really affecting my self-esteem and confidence (Participant C: focus group 23\12\2004).*

Participant B's reacted by starting to avoid the cause of the problem:

*What regularly happens to me is that I just put it off and put it off (Participant A: focus group 23\12\2004).*

Believing in her own abilities is very important for Participant C, and the uncertainty surrounding the injury caused a lot of self-doubt and anxiety.

*For me, one of the biggest difficulties is not knowing yourself and your own abilities. Before the injuries I knew exactly what I was able to accomplish in a certain amount of time, and now I'm am always worrying about how long I would be able to play before my hand gets sore again. It's very demotivating (Participant C: focus group 23\12\2004).*

Participant B experienced the same kind of insecurity:

*You limit yourself as a player in your head and that's a problem when you are teaching other people. When your own playing is limited you can't be on top of everything you teach. It's an insecurity to not be able to do what you know you could before (Participant B: focus group 23\12\2004).*

Participant B was looking forward to a bright future as a musician. After being injured there was a dramatic change in the way he saw his future:

*After changing to new teacher, I suddenly thought, "wow, so this is how you do things!" There was a glimmer of hope of achieving my goal of being a concert pianist. After the injury, all hope disappeared and I decided just to forget about it (Participant B: focus group 23\12\2004).*

#### **4.2.2. The teacher couldn't help or advise**

During the focus group discussion, the participants agreed that there was a general lack of knowledge among their teachers about the prevention and treatment of injuries.

Participant B experienced pressure from his teacher instead of the necessary support:

*I was feeling pressure from my teacher pushing me to keep playing after being injured. I don't think that teachers in general know enough about injuries. Since my injuries first occurred, my teacher never gave me any advice regarding to stretching before practicing, and how to be more aware about preventing being injured (Participant B: focus group 23\12\2004).*

Participant A experienced a loss of faith in his teacher's abilities after the teacher was unable to guide him through this difficult time:

*My teacher was not particularly helpful with my injuries. He didn't quite know what to do - I suppose as a result of that I lost faith in him... I mean I still respect him, but at that age the teacher is a real authority figure and you just lose faith (Participant A: focus group 23\12\2004).*

Participant C experienced similar doubts, and was disappointed in her teacher's inability to provide sound advice and guidance in the beginning stages of the injury:

*It was scary, because you go to your teacher for answers like that. I think that all teachers should be forced to complete a course on the prevention and treatment of injuries. I found it extremely scary when my teacher was unable to help and was as uncertain as to how to proceed as I was (Participant C: 23\12\2004).*

During the focus group discussion it became clear that the inability of the teacher to provide guidance during the most critical initial stages of the injuries could potentially have very serious repercussions.

#### **4.2.3. Change in Occupation: An alternative career**

Participant A has found a very satisfying and successful alternative to his original occupation, but does not think that it could be successfully combined with his previous occupation:

*I started getting interested in conducting - as the injury flared up I concentrated more on conducting. That's also why I'm pursuing my interest in conducting. But conducting comes with an entire set of it's own difficulties and possible injuries. It would be very difficult to carry on with both interests at once - firstly, there won't be enough time, and secondly, the movements that are associated with conducting are not at all helpful towards my viola playing. It creates a lot of tension in your shoulders and elbows, which is not at all helpful towards viola playing (Participant A: focus group 23\12\2004).*

As a result of the injuries, Participant B started considering a drastic shift in occupation, even to something completely outside of music:

*I started looking for other things that I could incorporate in music. I considered a lot of things, and that developed into being open to things completely outside of music (Participant B: focus group 23\12\2004).*

Participant B feels that his teaching abilities would be affected by insecurities about his own skills as a musician:

*I think that it creates so much insecurity when you have to teach but you are not able to do what you could before the injuries (Participant B: focus group 23\12\2004).*

Having had the experience of being injured, Participant A feels that such a person would very often be able to provide sufficient guidance to others in similar situations:

*I think that very often, people who have had injuries can become very good teachers at a certain level (Participant A: focus group 23\12\2004).*

Participant C is confident that she would have the ability to play a vital role in guiding fellow musicians who are faced with the same problems, and in that aspect feels that teaching would be a good alternative to her original choice of occupation:

*I think I would be able to help someone with preventing injuries and I would be able to provide the person with guidelines as to go about treating it (Participant C: focus group 23\12\2004).*

The participating musicians did not experience the effects of the injuries on their alternative occupation in the same way. Two of the participants felt that the experiences acquired through being injured could be used in a positive way, helping other musicians and guiding them through the different stages of their injuries. The third participant felt that his own injuries created self-doubt about his abilities as a musician, and therefore also about his abilities as a teacher, therefore having a negative impact on his alternative career choice.

In this chapter I have described the findings of the focus group participants regarding their injuries. The main findings were that the injuries had a dramatic effect on the emotional well being of the participants, creating feelings of self-doubt, fear, loss of joy and spontaneity in their music, disappointment, demotivation and paranoia. These feelings resulted in uncertainty about the future, loss of faith in their teacher's abilities, and being forced to having to adapt to an alternative career, causing additional stress and unhappiness.

## **Chapter Five**

### **Discussion of Results, Conclusion and Recommendations**

#### **5.1. Discussion**

In this chapter my findings from the previous chapter will be discussed mainly at the hand of the theoretical framework based on Kielhofner's Model of Human Occupation.

It is mentioned in a previous chapter that, according to Kielhofner (1997), the human system can be divided into three subsystems: volition, habituation and performance. When my findings are discussed in terms of volition, it becomes clear that the injuries had a large impact on how the participants' were able to judge their own ability to manage certain tasks- tasks that were part of their daily occupation for most part of their lives, in this case practicing their instruments.

##### **5.1.1. Volition**

Kielhofner (1997) explains that volition is composed of an underlying energy source - the energy source that urges individuals to explore their environment and master tasks over the course of their lives. The Model of Human Occupation proposes that occupational choices made by individuals are influenced by the images that individuals hold of themselves in the external world. This is influenced by the degree of control experienced in certain situations and with certain activities, and therefore identifies personal skills. This sense of personal skills will influence which occupations will be sought out and which will be avoided. Avoiding a specific occupation results in a growing feeling of fear and helplessness.

From the research findings, the focus group participants had sought out and practiced the occupations best suited to them, affirming the self-evaluations that guided them in the direction of becoming musicians. Their injuries had an effect on how they were approaching their tasks or any related tasks, not knowing whether they were still

capable of creating satisfactory results, and in a sense not knowing how to evaluate their own self-worth.

The participants chose their specific occupation as a result of various factors, including upbringing, individual taste, and wanting to make sense out of their lives. The inability to continue with their chosen occupations resulted in loss of self-esteem, feelings of self-doubt, fear and loss, as well as uncertainty and negativity towards any alternative occupations. According to Kielhofner (1997), selecting an occupation can be compared with choosing a specific, continuation of a story in which we see ourselves. The inability of the focus group participants to continue with their chosen stories had a vast effect on their psychological and emotional well-being.

### 5.1.2 Habituation

Kielhofner (1997) states that “Habituation holds together the ordinary fabric of our lives”. Habits can be defined as tendencies acquired through previous repetition, through which people learn to behave efficiently in their environments. Roles act as guidelines as to who a person is in a certain context, implying specific rules of behaviour, and therefore shaping the identity of a person. Kielhofner explains that:

*The social appropriateness of habits is critical since patterns of behaviour must conform, to a degree, to accepted patterns in the social group if the individual is to be judged competent (Kielhofner, 1997:3).*

When these habits and roles are interrupted, the structure and stability created by these habits and roles are disrupted, causing immense emotional and psychological trauma. The participants described their experience of interruption in their habituation, their tools of behavioural construction were temporarily lost, causing anxiety, fear and paranoia. The initial sense of inability to regulate how time is being used, the absence of the regular performance of certain activities, and the temporary loss of self-identity was only a few of the devastating effects that the injuries had on the focus group participants (Kielhofner, 1997:2).

### 5.1.3. Performance

As mentioned in a previous chapter, the performance subsystem deals with the spontaneous organisation of certain actions in order to accomplish a certain occupation, and a complex interplay of the musculoskeletal, neurological, perceptual, and cognitive phenomena is one of the components needed for the subsystem to function properly. The research results revealed that the participants suffered from injuries that resulted in certain musculoskeletal disorders, causing the malfunctioning of this essential subsystem.

All three of the above mentioned subsystems must cooperate in order for the human system to function in the course of daily life (Kielhofner, 1997:3).

As mentioned earlier, the environment also plays a very important role in occupational behaviour. After sustaining injuries, the focus group participants experienced a dramatic change in their environment, affecting them in a negative way. The musicians were feeling pressured by the expectations of those around them, including teachers and fellow students. The inability to live up to the expectations of others created a very uncomfortable and demoralizing environment for the focus group participants, contributing to their emotional and psychological stress.

From data that emerged from the focus group research, it became clear that being able to practice your occupation is essential for both emotional and psychological well-being. According to De Witt (2002:3), research has identified occupation as being important for human health. She explains that occupation provides a way to meet all basic, safety and sustenance needs of a human being in order to exercise and maintain physical, mental and social capacities and keep them in balance. Csikszentmihalyi (1993) captures the essence of occupation:

*...playing a challenging piece of music...is the kind of experience that focus our whole being in a harmonious rush of energy, and lift us out of the anxieties and boredom that characterizes so much of everyday life (Csikszentmihalyi, 1993:38).*

Kielhofner (1997:104) adds that the human system is carried along and shaped by the nature of its occupational behaviour:

*As the human system engages in action, that action or behaviour is imprinted on the human system...when human systems behave, they become, in some real measure, what they do. Occupational behaviour is a dynamic process through which we maintain the organization of our bodies and minds (Kielhofner, 1997:104).*

He continues by stating that when we work, we are not merely performing our occupation, but organizing ourselves. Through this we create our self-concepts and our social identities.

The results from the data illustrate the influences of occupational dysfunction on the emotional well-being of the musician, creating feelings of self-doubt, loss, fear, paranoia, and demotivation. By studying these examples the importance of occupational well-being becomes clear and is confirmed by Csikszentmihalyi statement:

*The depth of concentration required by the fine balance of challenges and skills precludes worrying about temporary irrelevant issues. We forget ourselves and become lost in the activity Csikszentmihalyi (1993:39).*

After acquiring the injuries, it seemed that the musicians experienced a drastic shift in their state of well-being, and became almost consumed by feelings of doubt, self-doubt, paranoia, and loss of confidence and self-esteem.

The art of being a musician requires a large amount of emotional involvement, and at the same time acts as an emotional outlet to most musicians. Being deprived of the ability to express one's emotions can also cause a lot of emotional stress, adding to the above-mentioned feelings of the musicians. This could create the feeling of not being in control of your emotions. Csikszentmihalyi (1993:39) confirms this by stating that the well-matched use of skills provides a sense of control over our actions.

*Because we are too busy to think of ourselves, it does not matter whether we are in control or not, whether we are winning or losing. Often we feel a sense of transcendence, as if the boundaries of the self had been expanded...the flow is so enjoyable that a person will want to repeat whatever activity has produced it.*

## 5.2. Conclusion

Findings that emerged from the research data indicated that the participants suffered emotionally and occupationally from the effects of their physical injuries. Similar results were confirmed by the literature. Apart from the great amount of physical pain and discomfort caused by these injuries, mainly as a result of carpal-tunnel syndrome or over-use, the occupational loss and injuries also has a vast impact on the emotional and psychological well-being of these musicians. The result was that the music student doubted if they would be able to follow their chosen career as musicians. The occupational dilemmas created more emotional discord.

The findings of this study clearly revealed that the psychological and emotional impact on the participating musicians were the most severe. The emotions most experienced by the participants were feelings of fear about and loss of their chosen occupations. Fear of further injury as a result of inadequate guidance was present among all of the participants. The fear of failure as a musician resulting from being held back by their injuries was also common among the participants. Two of the participants feared that the injury was imaginary, and that they were imagining the injury in order to avoid the stress and workload associated with their profession. Loss of joy and excitement about the occupation, loss of their first choice of occupation, loss of motivation, loss of self-confidence and self-esteem, as well as loss of enthusiasm were factors that were influencing the participating musicians in their new, or adapted form of their previous occupations.

A great deal of the musicians' emotional and psychological suffering could have been prevented by early and appropriate guidance from their teachers, as well as sound advice from medical specialists. The researcher acknowledges that injuries and intervention are not a part of a music teachers' role. However, the findings of this research highlight the importance of awareness of these aspects to injury.

The physical injury nature of injury should have been identified immediately, and further advice with regards to medical attention should have followed immediately.

This would have prevented the feelings of uncertainty and paranoia accompanying such an injury, as well as the psychological effects of not knowing the origin of the pain. Appropriate guidance could have helped students decide how long should abstain from playing their instruments to fully recover from the injury, and also instructions as to how a similar injury can be prevented in the future. This would prevent the feelings of fear, doubt and self-doubt associated with not knowing for how long to rest before resuming practise, and how to practise in order not to injure yourself again. The teacher should refer their students the appropriate medical specialist, preferably a medical specialist with previous experience with similar injuries.

The role of the medical specialist is of crucial importance, seeing as the musician has very little choice whether or not to follow the specialist's advice. It was the experience of all of the focus group participants that the medical specialists treated symptoms, and not the origin of the problem. When the injury for instance occurred in the wrist, the wrist was treated in isolation from the rest of the human system, not considering the effects of their treatments on the rest of the body.

### **5.3. Recommendations**

My recommendations are that the music faculties of universities converse with the sports science faculties on the subject of injury treatment. There are currently intensive injury-treatment programs running at most Sport Science institutes, and it would be advisable for Music Departments to give more attention to this subject in aid of the emotional and psychological well-being of their students. Similar injury after-care programs should be considered, and it would be of great value for musicians to learn from the example of sport-related injury treatment and rehabilitation programs.

I recommend that emotional support programs should be made available at music faculties in order to advise, support and encourage music students suffering from injuries that prevent playing their instruments. This would also imply that an individual with a good knowledge of injury prevention, treatment and rehabilitation should be available for providing these students with the sound advice that they so

desperately need in that time. Group discussion sessions for injured musicians would also be advisable, as injured students could learn from each other's experiences.

I recommend that all music teachers, especially at university level, should be made aware of the effects of injuries and of basic injury prevention procedures.

Finally, I recommend further research. This qualitative study highlighted the lived experiences of three musicians following an injury that interfered with occupations as musicians. The results from qualitative studies do not offer the scope to generalize. In contrast, it yields in-depth descriptions of the experiences of a small group of people. To determine how widespread the problem occurs, a quantitative study with a large sample size could be undertaken.

University of Cape Town

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