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## EMPIRICAL STUDIES

**An occupational therapy approach to the support of a young immigrant female's mental health: A story of bicultural personal growth**

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**Abstract**

Young immigrants who suffer from psychosis perceive their illness from the outlook of at least two cultures, which is often a source of confusion and misunderstanding for clients, their families, and clinicians. This article presents a case study with a narrative approach, aiming to illustrate how an occupational therapy intervention can highlight the role of culture and address bicultural identification in a young adult immigrant woman with mental health problems. The results show how a culturally adapted intervention model can be used to help the client go through a transition from an interdependent to a more independent self. During the course of occupational therapy, the client gained greater insight into her problems and could view herself as integrating numerous facets related to two different social and cultural contexts. Moreover, the client achieved better skills in dealing with discrepancies and cultural contradictions and became capable of relying on either or both of the cultures in different situations.

**Key words:** *Young immigrant, psychosis, interdependent self, occupational therapy*

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Adolescents from ethnic minority groups face challenges when trying to adapt to two cultures simultaneously, their own ethnic group and the mainstream or dominant culture (Frie, 2008; Phinney, 2004; Phinney & Horenczyk, 2001; Sam, 2000). This makes the process of identity formation complex, and research suggests that successful identity development for immigrant adolescents entails the creation of a bicultural sense of self in which the individual feels attachment to and competence in both cultures (Sam, 2000). Difficulties in adapting to two cultures are increasingly recognized as a major clinical concern in the area of mental health care and have been addressed in research. It has been argued that two types of cultural orientations, namely, collectivistic and individualistic worldviews, respectively, influence the conceptualization of the self (Iwama, 2006; Markus & Kitayama, 1991; Triandis, 1995). Markus and Kitayama (1991) assumed that people in collectivistic cultures view the self as being shaped in an interdependent

relationship. An interdependent self-construct is based on the belief that the self and others are intertwined, whereas an independent self-construct is based on how people perceive themselves, as separate from others (DeCremer, 2005). The main conflict a person experiences within an interdependent system concerns social norms, values, and expectations. Self-concept and self-esteem have collective meanings and depend on the family's reputation and approval when the self is not differentiated from the family's identity (Dwairy, 2006).

Studies in the Netherlands have shown that second generation young Turkish females tend to have significantly more mental health and behavioral problems than young Turkish males. A possible explanation to this finding lies in the weak position of women in the traditional male-dominant Turkish culture. When immigrant girls are brought up in a host culture in which females are allowed to make their own decisions, they are faced with the discrepancies between the female position at home and

that of the society of settlement. Such discrepancies, which may reach their peak in adolescence when the young woman still lives with her parents, could lead to a conflicting and stressful situation and might increase the risk of mental health problems in second generation girls (Darwish Murad & Joung, 2003; Darwish Murad, Joung, Verhulst, Mackenbach, & Crijnen, 2004). The multiplicity of cultural references is often a source of confusion and misunderstanding between families and treatment teams (Rousseau, Key, & Measham, 2005). In clinical mental health work, it is thus important to acknowledge the cultural attributes of the individual client and how these might affect the therapy (Nelson, 2007). Severe mental illnesses such as schizophrenia disrupt an individual's customary sense of self, the sense of boundaries between self and others, and the ability of the self to relate meaningfully to the cultural world (Faberga, 1989).

One of the challenges of the mental health care system in Sweden is the question of how to provide services that meet the diverse needs of immigrants. Poor integration of cultural knowledge into clinical practice can result in a sense of dissatisfaction and disharmony for both client and provider (Black & Wells, 2007). Cultural awareness is necessary for the delivery of mental health care according to MacRae (2005) and should be addressed not only in the treatment process but also in the stages of evaluation and making diagnoses (Lim, 2008; Mishne, 2002). Immigrant adolescents who suffer from psychosis perceive their illness from the outlook of at least two cultures. The multiplicity of cultural references is often a source of confusion and misunderstanding for both the affected families and the treatment teams (Mattingly & Lawlor, 2000; Rousseau et al., 2005). A clinician who is thus unfamiliar with the nuances of an individual's cultural frame of reference may incorrectly assess as psychopathological those normal variations in behavior, belief, or experience that are specific to the individual's culture (American Psychiatric Association, 2000).

Occupational therapy in mental health care is an arena where cultural dilemmas are highlighted, being as it deals with people's everyday life and habits. Previous studies (Pooremamali, Persson, & Eklund, 2011a; Pooremamali, Persson, Eklund, & Östman, 2011b) have revealed that therapeutic interventions are often not synchronized with the realities of immigrant clients with mental illness because of differences in worldviews between clients and staff. In addition, findings from these studies indicated that existing occupational therapy models may not work optimally with immigrant clients. Independence and autonomy are highly

valued in Western occupational therapy theory (Kielhofner, 2008), which means that the self is viewed very differently from how it is in Middle Eastern cultures, which emphasize interdependent relationships and the primacy of the family and the community (Dwairy, 2006). Being as occupational therapy is practiced and delivered and has been developed in the Western countries it reflects a Western perspective and philosophy of life, occupation, health, illness, and well-being and therefore limited in terms of cultural appropriateness and sensitivity (Iwama, 2007; Lim, 2008). In order for occupational therapy to become truly multicultural it must be able to embrace multiple truths and employ varied techniques that acknowledge diverse myths and symbols of different cultures (Kelly & McFarlane, 2007). However, narrative can play a potential role in helping to illuminate the world of the client especially when there are large differences between the cultural backgrounds of professionals and clients (Mattingly & Lawlor, 2000).

The aim of the present study was to illustrate how an occupational therapy intervention can address bicultural identification in a young adult immigrant woman with mental health problems. For this purpose, a case study with a narrative approach was performed.

## Method

### *Study design*

A descriptive single case study was used in order to present a complex description of a phenomenon within its context (Yin, 2003). Case study research has a long history within the social and behavioral sciences and has been central to the development of knowledge in counseling and psychotherapy (McLeod, 2010; Salminen, Harra, & Lautamo, 2006). Case study research enables the investigation of complex systems in real life. It offers a way to investigate occupational therapy interventions and to study what these mean to the client (Salminen et al., 2006). The case study presented in this paper covered a period of 2 years and took place in a naturalistic context within the frames of the therapy described below.

Ethical approval for conducting this study 4 years after the therapy was sought and obtained from the local Research Ethics Committee. The participant was asked if she agreed to the study being carried out and was assured that all information was confidential and that participation was voluntary. Her written informed consent was obtained.

*The setting and the standard therapy*

The occupational therapy intervention was carried out at a psychiatric rehabilitation center, which was part of a psychiatric unit and was staffed with 15 mental health care workers including social workers, nurses, and occupational therapists. The majority of the more than 500 clients were immigrants (first and second generation) with various ethnic backgrounds. The occupational therapy was mainly based on occupational therapy models of practice with the client as the focus of the treatment. The general aim of the occupational therapy interventions was reconstructing the clients' abilities to function and perform daily life tasks and engage in activities. The standard evaluation and assessment tools used by the occupational therapists in the unit were based largely on Western occupational therapy including the Canadian Model of Occupational Performance (CMOP; Law et al., 1998) and the Model of Human Occupation (MOHO; Kielhofner, 2007) and the cultural values, standards, and norms reflected in them. The MOHO provides a broad and integrative view of human occupation and how occupation is motivated, organized, and performed in the environmental context (Kielhofner, 2007). The model offers guidelines for occupation-focused practice, and the individual is seen as being made up of three interrelated components—volition, habituation, and performance capacity (Finlay, 2004). Volition refers to the motivation for occupation, habituation refers to the process by which occupation is shaped into patterns and routines, and performance capacity refers to the physical and mental abilities that cause occupational performance (Kielhofner, 2007). The CMOP (Law et al., 1998) is based on ideas about client-centered practice (Finlay, 2004). The main emphasis of this model is on the meaning of occupation, the uniqueness of the individual, and the significance of engaging the individuals in shaping their own interventions. The concept of occupation is divided into three performance areas: productivity, leisure, and self-care, each comprising some performance components or functions. Both models emphasize the client and the therapist as equal partners in the therapy and the importance of the psychosocial, cultural, and physical environment in understanding and treating the client's problem because the environment is the context in which occupation occurs (Finlay, 2004; Kavanagh, 2006). Further, the rehabilitation was also based on psychiatric and psychological knowledge gained from a multiprofessional psychiatric rehabilitation program (Anthony, 2002). In addition, creative activities were routinely used as a treatment medium. Engagement in creative activities may stimulate a sense of

achievement, growth in self-confidence, and the development of skills; promote some control of negative thoughts and feelings of stress; provide a sense of purpose and meaning; and contribute to the development of a personal identity (Creek, 2008; DeWitt, 2005; Griffiths, 2008; Gunnarsson & Eklund, 2009). Immigrant clients generally received the same kind of treatment and care as Swedish-born clients.

*The participant*

The participant, Dilbar (fictive name), was a 22-year-old woman of Turkish origin who had her first psychotic breakdown at the age of 13 years. Since then she had spent a significant part of her life in psychiatric hospitals and had received psychiatric treatment, including psychotropic medication, on a regular basis. Dilbar was the oldest of four siblings and had a close relationship with her mother in a traditional authoritarian family system in which the father is the head and therefore was the collaborator with the health care services and other authorities. During the initial phase of the treatment, the mental health care team members saw the family, especially the father, as the cause of many of Dilbar's problems and one of their treatment goals was to support her to become more independent from the family. The team even separated Dilbar from her family for a while by placing her in a treatment home with the aim of developing her ability to lead an independent life. The family was dissatisfied with the team's involvement in the girl's life. Consequently, they initially refused to collaborate with the health care system. At the time of the referral to the occupational therapist, Dilbar was hospitalized in the acute psychiatric ward due to a relapse that occurred when she was moved to another city and began studies tailored for adults with psychiatric disabilities. This was the first time she lived alone. On the fourth day she experienced hallucinations and delusions about snakes coiling around her body and trying to get into her head. She was scared and ran away from the room. As a result of this incident she was admitted to the acute psychiatric inpatient ward and was subsequently hospitalized for 2 months. After the first month the occupational therapist began to see Dilbar. Dilbar was depressed, withdrawn, apathetic, and almost unable to get out of bed. She also had problems expressing herself verbally. In order to establish contact the occupational therapist (author PP) frequently visited Dilbar in the acute ward.

When Dilbar was discharged, she was offered outpatient occupational therapy. Dilbar's days consisted at that time of long periods of lying in bed or standing in darkness in her room, and sometimes she

spontaneously made paintings of snakes, blood, fire, and the devil. Her mother and sisters helped her with self-care activities. She was sick-listed and had a passive lifestyle without structure or routines and she lacked the motivation and volition to perform the roles and occupations required for the course of an independent daily life. She also was overweight and she was unable to use ordinary public transport without assistance because of anxiety and fear of being followed by the snakes. She also feared walking around or visiting places on her own because she imagined that the snakes followed her everywhere. The only place where she had some control over her hallucinations was her dark room. The occupational therapist conducted home visits and tried to develop a therapeutic relationship with Dilbar and the family. The therapist used both Swedish and Turkish when communicating with Dilbar's mother. With the other family members, only Swedish was used.

#### *The course of occupational therapy*

Dilbar had therapy sessions once a week for 2 years and many of these were home visits. The therapist (author PP) had occupational therapy training at the master level, further education in psychiatric rehabilitation and a transcultural psychiatric program, and extensive experience from working in mental health care settings with clients from different ethnic groups. She used an integrative occupational therapy approach, relying partly on the standard therapy but adding methods and techniques that took the client's cultural background into consideration. Creative activities such as painting were used as a therapeutic tool in establishing a collaborative and trustful relationship, involving the client in the therapy and identifying her problems and needs. Painting and describing her problems in metaphors became a recurring and important element in the therapy sessions. Dilbar was encouraged to create meaning and connection between the metaphors in the painting and the events in her life. Then she was asked to find alternative practical solutions that would change the metaphors. Finally, the client was guided to utilize the practical solutions in the real world through engagement in meaningful occupations in order to strengthen the ego through reality testing (Ikiugu & Ciaravino, 2007; Stein & Cutler, 2002). In addition, different psychological approaches, especially object relations theory, were combined with occupational therapy knowledge, which offered the therapist analytical tools to work with particular problem areas (Finlay, 2004). The paintings served as transitional objects, which promoted communication and the establishment of a

transitional space between the client and the therapist in which the therapy took place (Eklund, 2000). A narrative interview was made in relation to each painting including a comparison between the paintings in the course of the therapy and served as an assessment tool. In addition, the therapist observed Dilbar's interaction with others and her performance of activities and used a variety of assessment tools and instruments related to the CMOP, the MOHO, and the psychiatric rehabilitation program (Anthony, 2002). These methods gave a basis for assessing the client's skills, liabilities, and performance of tasks within different contexts and gave an idea of the sources of obstacles and influences in the environment.

The purpose of the therapy was not to focus on intrapersonal aspects in the psychodynamic sense, but rather on how the client engaged in everyday activities. A sensitive balancing between the values of independence needed in her new culture and the interdependence expected from her original culture was essential in the therapy. Furthermore, a fit between the client's capacity and the challenges that the occupational activities provided was seen as vital. The intervention plan was based on cultural sensitivity and included the following elements:

- (1) A step-by-step individually and culturally adapted technique for illness management and recovery (Mueser et al., 2002) in which Dilbar learned new strategies for managing her illness and coping with the stress caused by her symptoms.
- (2) A stepwise bicultural personal growth program including techniques for self-exploration, competence, and achievement inspired by Kielhofner (2007) was constructed and served as the major therapy. Self-exploration included a process of discovering and comparing differences and similarities with regard to the Turkish and Swedish cultural worldviews and value systems and was based on the following topics: (a) to build awareness of Dilbar's Turkish cultural heritage, as well as the Swedish; (b) to identify the negative and positive aspects in both cultures, as well as similarities and dissimilarities between them; (c) to identify feelings, thoughts, and experiences related to positive and negative cultural aspects in daily life (home and school, past and present); and (d) to find alternative ways of dealing with the negative aspects identified in both cultures. By the competency process, Dilbar strove to develop adequate behavior and skills (a) to meet environmental demands and expectations, (b) to build up coping skills that would

enable her to function in diverse settings, and (c) to grow social and communication skills that would enhance self-determination. The achievement process included integrating different cultural values in daily life and improving her sense of control, which allowed her to participate in and accomplish various everyday activities.

- (3) Social skills training based on five principles “modeling, reinforcement, shaping, overlearning, and generalization” (Bellack, 2004, p. 46) and a range of appropriate, personally tailored interventions related to independent life and housing (Lieberman, DeRisi, & Mueser, 1989) were constructed to encourage Dilbar’s development toward an independent life.

On the basis of the above-mentioned therapeutic ingredients, an intervention plan was constructed. Dilbar was gradually engaged in concrete task-oriented activities outside her home. Those activities were such that she found meaningful and led to new interests and discovery of her aptitudes and preferences. The family members were involved in supporting and monitoring the planned activities.

*The collected data*

The data used for this study consisted of notes taken during the course of therapy, clinical documents such as assessments and intervention plans, a reflective diary about different events during the therapy, and paintings made by Dilbar, either made spontaneously or as an element in the therapy. The data related to the first part of the course of occupational therapy mainly focusing on storytelling and on Dilbar’s life experiences, both of the past and present. It involved field notes about communication, conversations and observations of the client and her family in the clinical as well as the home and outdoor settings. The data concerned the family history, including the issues of migration and acculturation, and Dilbar’s personal life history involving the stories of her identity and illness and her occupational history. The client was asked to bring one or more of the pictures she had painted during her psychotic episodes before the therapy in question and select those which were of personal value to her. These pictures were useful in capturing aspects that conversations and interviews had left out and that could not be expressed in words (Craib, 2000) and formed part of the data used for this study. The field notes that concerned the latter part of the therapy concentrated on the present and thoughts about the future and the focus of those data gradually shifted from the activities that were

important in Dilbar’s life toward conversations about herself and her identity. The participant was asked to paint and bring a new painting to the therapeutic session every 3 months. In all, six new paintings were part of the data. All information was continuously recorded in accordance with the Swedish regulations on medical records. In addition, the occupational therapist continuously wrote down field notes of observations and conversations that had taken place including discussions about the paintings, as well as a number of metaphoric proverbs that were important to Dilbar. Included in those field notes were also the occupational therapist’s reflections on the therapy sessions.

*Data analysis*

Narrative research is a form of “meaning making” that recognizes the meaningfulness of individual experiences as parts in a whole (Polkinghorne, 1988). A central task in narrative research is to provide coherence to the confusion and chaos generated by illness (Mattingly, 2004). The data analysis (Figure 1) took place 4 years after the case was completed and was organized in phases. In the first phase of analysis the field notes were thoroughly reviewed by the first author. In the second phase they were subsequently analyzed in accordance with the narrative analysis approach described by Polkinghorne (1995). During that phase, the researchers organized the data elements into a coherent account. All text elements that described events, occurrences, feelings, thoughts, meanings, relationships, symbols, metaphors, and beliefs were identified, color-coded, and grouped together based on common factors. Furthermore, a brief summary and reflections were written next to the highlighted element. Besides the field notes, all paintings and the metaphors were used in the analysis for gaining insight into the client’s thoughts and feelings on her life. In the third phase Polkinghorne’s adaptation of Dollard’s criteria (Polkinghorne, 1995) for examining significant life events and experiences were used.

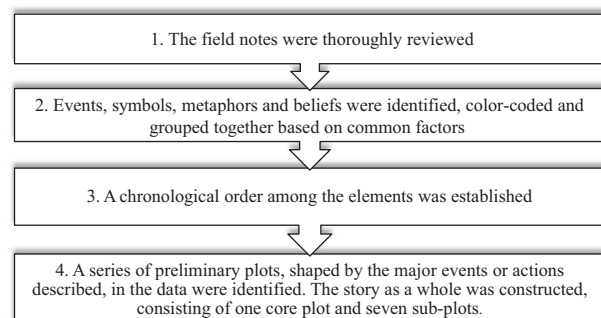


Figure 1. The different phases of the narrative analysis.

These criteria concern, for example, contextual features, the central character's personal goals and actions, the other individuals who have had a significant impact on the actions and goals of the central character, the historical continuity and previous experiences, and the discernment of a bounded temporal period with a beginning, a middle, and an end. The final consideration among those criteria concerns the plausibility and understandability of the story line and the discernment of how the disparate data elements may form a meaningful explanation of the character's responses and actions. In this third phase, a chronological order was thus established among the elements, which according to Polkinghorne (1995) is a requirement for a story. At this point it was clear that the paintings not only had the power of generating and brightening the subtle nuances and meanings, but also the ability to structure the narrative data. In fact, the paintings provided a running chronology of happenings and events in the participant's narrative and some of them formed symbols of the major plots in the participant's journey toward a bicultural self. As a result, the paintings were used as a vehicle for getting a sense of the whole narrative in "its temporal dimensions i.e., a beginning, a middle, and an ending" (Polkinghorne, 1995, p. 15). In doing so the paintings also became an integral part of the story about Dilbar and the therapeutic process she went through. The fourth phase was about creation of the core plot and sub-plots. According to Polkinghorne (1995), in a story, events and actions are drawn together into an organized whole by means of a plot. "A plot is a type of conceptual scheme by which a contextual meaning of individual events can be displayed" (p. 7). The product at this point was a series of preliminary sub-plots, shaped by the major events or actions described in the data, which were then further organized according to how they were related. The causality behind happenings, events, and actions was then also identified in order to add meaning and make more sense of the data. The co-authors, representing different scientific disciplines, were involved in the process of organizing the data into a coherent story, while also repeatedly reverting to the original data to recheck and validate meaning. The data elements were gradually configured into a story that united and added further meaning to the data. By this fourth phase the story as a whole had been constructed, consisting of one core plot and seven sub-plots that showed essential features and formed a story about bicultural identification in a therapeutic context.

## Result

The analysis led to a core plot denoted; a bicultural personal growth, which comprised seven sub-plots that in chronological order were termed: the invisible self, the ill self, the caged self, the confused self, the fearful self, the released self, and the integrated self.

### *The invisible self*

Based on the worldview of the culture to which Dilbar and her family belonged, engaging her in therapy required reciprocal negotiation and collaboration with the family, especially with her father. Gaining a trustful relationship with Dilbar and her family was challenging, particularly since they mistrusted the mental health care system due to previous negative experiences. The occupational therapist made many home visits in order to develop a sense of *mahram affinity*<sup>1</sup> and to maintain a trustful relationship with the whole family. There were cultural affiliations between the therapist and the family that played a significant role in generating a trustful relationship. Talking about their countries, culture, and experiences of migratory lives had a pivotal role in developing a close relationship. The therapist gradually became one of the family's *mahram*, which made it easier to take decisions about the procedure of occupational therapy while engaging both the client and her family. Step-by-step the client engaged more in the therapy process and the father's previously dominating role diminished. This process of an evolving relationship also provided an opportunity to rebuild trust and reawaken the client's and the family's interest and cooperation. It was obvious that Dilbar defined herself as an inseparable part of the family and her relatives. It was mostly the parents, especially the father, who decided about Dilbar's life. He was very protective and it was important to obey his rules. Dilbar did not view the father's authoritarian role as restricting; in contrary, her strong Turkish cultural beliefs made her feel that the parents' strict upbringing of herself and her sisters was normal. The mother and the sisters were a source of support and love and they and Dilbar had very close emotional bonds. She blamed herself for being unable to take on the responsibility of taking care of her mother and younger sisters, which according to their cultural values was an obligation assigned to the eldest child. Following the process of an evolving relationship, Dilbar was asked to select and bring one or more of the previously painted pictures to the next session. A picture (not displayed here) depicted a treatment session that took place while she lived in a treatment home a few years previously. That picture showed a room: on one side there was a woman who had a pen

and a paper in her hands. On the other side of the room a man was standing and a woman who sat with her head bent. Between them was a woman with her eyes closed and her mouth open in a scream. This picture became a tool for story-telling about her course of treatment, which had lasted more than 11 years. She described a variety of people in the psychiatric care services and other authorities who formed part of her life in an irregular manner. She had been frustrated, exhausted, and distressed when her mother had been crying and her father had been angry in the meetings with the psychiatric team. She could not be open and talk freely about what was bothering her because of the Turkish cultural norm that obliged her to show respect toward her parents by being quiet and polite. The treatment staff, however, misinterpreted her non-disclosure behavior as an act of being frightened of her parents. They could not understand each other and she did not understand any of them. She thus became increasingly withdrawn and felt that she was invisible and that nobody cared and noticed her. She was increasingly frustrated and could not stop the thoughts that just ran around in her head and then transformed to evil, snakes, and pain.



Figure 2. The ill self.

### *The ill self*

The first painting that Dilbar made during the therapy sessions depicted a tree situated outside her bedroom window in the family's apartment (Figure 2). She started talking, however, about a tree located in the garden of her old elementary school, resembling a tree in her grandparents' garden in Turkey. When attending elementary school, she used to play alone under that favorite tree of hers. When she became sick, she hallucinated about snakes surrounding her favorite tree. After a while, she thought all trees around her were wrapped by numerous snakes, blood, and fire; she thus refused to look at her surroundings and especially avoided the trees. During the process of her therapy, however, she dared to look at a tree that was outside her bedroom and saw only two snakes coiled around the tree, and this was the tree she had painted.

The next therapy session took place physically under that tree, located outside her apartment, in order to make contact with the real tree. She was encouraged later on to draw a new picture of the tree, and her new painting showed a normal tree. After comparison of the two pictures she was asked to describe and note similarities and dissimilarities between her painted trees and the real tree and to tell the story about the trees and herself. At the time, the primary therapeutic goal was to strengthen her ability to cope with her destructive hallucinations. The illness was central in the story about the trees and was in some respects created and controlled firstly by God and secondly by the medicine. The hallucinations were, according to her story, a punishment by God that had allowed the Devil to enter her brain. The Devil was transformed into many snakes that were fighting to come closer to her and tried to coil around her body and to creep into her head and made her an "abnormal" girl. Part of her tree and illness story was also an insight regarding her illness including awareness about the current and past episodes of psychosis. The story also revealed that her troubles started at school; she had learning difficulties and needed extra help with reading and writing. Her illness then prevented her from completing secondary school education and still made her unable to take care of herself. One part of her life story revealed a happy, lively, and kind girl who helped her mother with domestic activities such as caring for her younger sisters until the time she became ill at the age of 13. Her ill self meant days of "doing nothing" and of having no interests, little family involvement, and no involvement in work or studies. She refused to go out because the snakes followed her everywhere, and she was enclosed in her role of being ill and having passive



habits. While the ill self prevailed, she was still able to identify fashion, painting, and domestic activities as interests, although she did not currently pursue these hobbies in any meaningful way. She had a poor sense of meaning in her life and felt that it was out of control. She could not identify any skills that made her feel proud or competent with the exception of some activities she had done prior to her first illness episode.

### *The caged self*

After 3 months of therapy, Dilbar was asked to draw a picture of how she could release the tree from the snakes. The second painting (Figure 3) was about two snakes enwrapping a human body. She spoke of how two snakes moved slowly from the tree and then coiled up her body but not violently. They were not extremely evil and she was not as afraid as before. She prayed with the intention of being relieved from the snakes but that did not help. She saw the snakes as devils, creating a cage in which she felt as though she was a jailbird.

By using the Turkish metaphoric proverb “*AçIn halini tok bilmez, hastanIn halini sağ bilmez*” [A satiated man does not know what hunger is, a healthy man does not know what disease is], she tried to describe her feelings of loneliness and



Figure 3. The caged self.

abandonment in daily life. She was asked to tell what the metaphor alluded to in her life and then described how her doctor and the other staff focused on the snakes and tried to remove them from her mind by drugs without seeing her as a sufferer. Her only solution and practical action for releasing the caged sufferer was by “praying.” While the caged self prevailed, the focus of the therapy was on increasing her motivation to explore some occupation-related solutions that might help her to cope with the stress of symptoms and distract her from destructive thoughts. Unexpectedly, she was able to mention some activities she would find meaningful, such as helping her mother with household activities, listening to Turkish music, and drawing fashion clothes. An intervention plan was devised and presented to her family for approval, with the hope that they would assist her and motivate her to perform the household activities and self-care activities. Dilbar began to realize that by doing activities she could influence her recovery, because when engaged in activities her hallucinations were less preminent. She reasoned in analogy with a metaphoric proverb, saying “*İşleyen demir pas tutmaz*” [Iron that works does not rust]. She described that the iron symbolizes desire, effort, and endurance for a better life in the Turkish culture. Through hard work, iron can transform into different things without losing its basic essential nature. This metaphor reflected her desire for a change in life and while the caged self prevailed, her psychotic symptoms were mostly under control.

### *The confused self*

The third painting (Figure 4) illustrated how two big snakes, each with one flag in their mouths, a Swedish and a Turkish, represented the two cultures. In this picture she was no longer a jailbird, but she was free



Figure 4. The confused self.

from the metaphoric slavery in the cage. This picture also demonstrated a transformation of Dilbar, from a passive, helpless jailbird to a released, although confused, being. This symbolized the beginning of personal growth for her. Figure 4 indicated that Dilbar had opened her eyes and could see what was going on in her life, but her mouth was still closed because she was still not able to express her will and dreams.

The secrets of the confused self, trapped between two flags, were revealed during the therapy, which while the confused self prevailed, focused on developing a culturally based intervention plan aimed at stimulating her and involving her in a process of personal growth linked with two cultures. Dilbar was asked to draw two pictures, one of a Turkish woman and the other of a Swedish woman, and make a list of the criteria and characteristics for each woman, positive as well as negative. She sketched a portrait of herself after comparing the two pictures and noted a variety of characteristics (positive/negative) on the portrait. The therapist focused on the client's selection of the characteristics and how they were linked with the bicultural frame of reference in order to enable Dilbar to detect specific cultural knowledge about herself. The narrative also revealed ambivalent feelings about the traditional values of her culture of origin. She idealized the Turkish culture at the same time as she criticized it. She was dissatisfied with the requirements of a traditional lifestyle, especially with the authoritarian role of men and the family hierarchy. Furthermore, the processes that took place while the caged self prevailed guided further rehabilitation goals with respect to her dependency on the transport service, which created an inactive and dependent lifestyle and had resulted in obesity. These problems were identified as a risky lifestyle and Dilbar agreed they should be prioritized. Her primary goal was to reduce weight. A structured skills training program including participating in a weight reduction program, physical training course, and walking was designed. Dilbar's youngest sister and mother agreed to accompany her a few times to the bus station in order to eliminate the dependency on the transport service. The therapist accompanied her to the weight reduction program and the physical training course for the same purpose. Dilbar's mother and sisters also helped her shopping and preparing food according to the weight reduction program. After a short time her dependency on the transport service was eliminated and she was able to take the bus herself. The desired outcome in weight reduction was, however, not achieved because of the side-effects of her medication, but her inactive lifestyle had been changed into a more active one. Dilbar wrote a weekly diary about her experiences,

feelings, and reflections related to the activities she performed. While the confused self prevailed, engagement in activities made her less preoccupied with and distressed by her psychotic symptoms.

#### *The fearful self*

The fourth painting (Figure 5) revealed two snakes that had become less prominent but covered the greater part of the eyes of a face with an open mouth. Part of the picture was also a crying heart. Dilbar showed in that picture that she had more courage to express herself, but that she was unable to open her eyes completely.

When experiencing a fearful self, by way of precaution, she could describe a changing life with personal growth toward "some independence." On the other hand, she talked about her fear of being unable to live independently of the family. She used the proverb "*Ana gibi yar, vatan gibi diyar olmaz*" [There is no lover like mothers, nor a place like homeland] to emphasize her ties to her family and country of origin. This proverb also reflected how her emerging self was based on group ties, loyalty, interdependence, and obligations. With the crying heart, the fourth picture also expressed the fear and sadness she felt and the safety she lost when starting to move from an interdependent to an independent



Figure 5. The fearful self.

self. This fear and sorrow were further manifested in another metaphoric proverb used by Dilbar; “*Benim kalpIm ağlıyor*” [My heart is crying from a deep sorrow]. She described how the metaphors were related to her anxiety and fear that a relapse could occur again, like when she experienced being separated from her family and being placed in a training school in another city. Her practical solution for changing the metaphor in such a way that would allow the transformation of the crying heart into a happy one was creating a balance between interdependency and independency in collaboration with her family. Involving her family actively in her process of personal growth was thus at the time essential in order for her to overcome her anxiety and fear.

#### *The released self*

The part of Dilbar’s narrative that related to the fifth painting (Figure 6) illustrated a bicultural personal growth in which she was increasingly able to maintain a balance between independency and interdependency. The snakes had disappeared, the sun was shining in her heart, and the opened mouth and eyes demonstrated that she saw herself as an active agent in taking decisions and being in control of her own life. She also described, however, her fear of not



Figure 6. The released self.

being able to control her illness; the shadows of snakes still tried to enclose her self, as indicated by the black frame in the picture. This fear made her withdrawn, reluctant, and distracted her from her goals.

Interestingly, the released self sub-plot was characterized by a connection between being involved in different activities and having less destructive hallucinations. She made many study visits to the community activity centers and schools together with the therapist, and eventually she felt prepared to take part in a 6-month pottery course. Some professionals, e.g., the teacher, a social worker and members from the mental health team, as well as herself and the family, became involved in devising the plan. The occupational therapist carefully assessed the skills required for taking the pottery course and whether these skills matched Dilbar’s capacities before the decision was taken. The motivation for being independent and active gradually increased during the course, as did her competency in particular tasks. When the pottery course was completed, she began studying in a municipal school for adults with psychiatric disabilities that included upper secondary education. She eventually completed the core subjects with a pass grade.

#### *The integrated self*

Toward the end of the therapy, Dilbar mentioned for the first time that she dreamt about leaving her parents and living by herself in her own apartment. She practiced role-play in order to prepare for a discussion with her parents without the involvement of her therapist. Surprisingly, her father agreed and supported her decision, while her mother opposed her relocating to another apartment. The therapist thus tried to involve the mother to a greater extent in the therapy and negotiated with her about the importance of accepting and respecting her daughter’s will. An apartment was arranged for Dilbar with help from the housing authorities, but prior to the move skills training related to an independent life was needed. A stepwise transition plan in consultation with her mother and siblings was developed in which the family members had different functions until Dilbar’s situation became stable. The therapist asked Dilbar, at this point in time, to draw a final evaluative picture of her overall life situation (Figure 7). Her painting of a landscape, divided by a stream but united with a bridge, illustrated how her two cultures had been integrated.

The therapy was terminated after comparing all the paintings, those drawn before as well as those painted during the intervention, so that Dilbar could reflect on what had improved, what had not



Figure 7. The integrated self.

changed, and how things were for her at that point in time.

### Discussion

The findings showed, in accordance with Frie (2008), how the client's bicultural experiences before the therapy in question had presented challenges that reinforced the onset of psychotic episodes. Previous research has emphasized the importance of recognizing how cultural differences impact on the meaning of the self (Laliberte-Rudman & Dennhardt, 2008; Yeh & Hwang, 2000). Swedish culture, as that in other countries in Western Europe, has been described as individualistic and its members are encouraged to believe in individual rights, personal freedom, autonomy, self-fulfillment, and the idea that the self is created through personal achievements and accomplishments (Hofstede, 1980). Self-worth is measured by personal achievement, and the individual is believed to be in control of his or her own destiny (Markus & Kitayama, 1991). Furthermore, the self is made meaningful mainly through a set of internal traits such as goals, needs, capacities, potential, and fulfilling one's roles (Laliberte-Rudman & Dennhardt, 2008). The findings from the present study confirmed those from previous research (Frie, 2008; Laliberte-Rudman & Dennhardt, 2008; Osyrman, 2004; Triandis, 1995), showing that the norm of an interdependent self is grounded in beliefs in social unity (i.e., families, groups, communities) that take priority over the individual. Turkish culture promotes, unlike the Western individualized and autonomous self, collectivism in which a strong, interpersonal relationship with family based on group ties, interpersonal relationships, loyalty, interdependence, duties, respect, and obligations are prominent (Imamoglu, 1998; Kagitcibasi, 1996,

2003). The therapist thus, from the onset, tried to generate a *mahram* relationship (Pooremamali et al., 2011b) with the family members by involving and including them in the client's therapy. Mutual trust, respect and collaboration between Dilbar, the therapist, and Dilbar's family was thus established. The family became an ally in supporting Dilbar as shown by Santoro, Sobocinski, and Klippel-Tancreti (2007) and Dwairy (2006), in moving toward bicultural personal growth and an independent life. The slow and steady progress in the discovery of self that took place in Dilbar could probably not have occurred without involving her family from the onset of the intervention.

The findings indicated that the paintings and creative activities had a function similar to that of transitional objects in Winnicott's notion (Ulanov, 2001) and served as communication paths between Dilbar's inner world and the outer world. The transitional space created this way was a kind of avenue, revealing the mystery behind the self and facilitating a process of identity formation and contact with reality (Ulanov, 2001). Meaningful activities in different contexts stimulated a process of externalization and internalization by which the client could develop relationships with others and learn new skills (Eklund, 2000). Furthermore, the findings confirmed the opinion by Stein and Cutler (2002) that, through use of the creative and expressive process, an occupational therapist can enable a client to develop a sense of self and insight into his or her feelings. The therapeutic use of activities may also have created a holding environment (Blair, Hume, & Creek, 2008) in which Dilbar could develop a reciprocal relationship with the outer world.

The findings also illustrated how the client went through a transition from an interdependent to a more independent and integrated bicultural self. The norm of an interdependent self was grounded in beliefs in social unity and sharing the family's values and norms as shown in these results for Dilbar. Excluding culture for such a client from the therapeutic process would thus, in accordance with Dwairy (2006), mean excluding a significant part of her existence, and this had happened during those treatment episodes when Dilbar became separated from her family for an independent life. As Dilbar told her story about her experiences, the past events, delusions, and hallucinations were reconstructed in a way that became more visible and comprehensible and as Garro (2000, p. 70) states "both past and present could make and shape future story." The results demonstrated the client's tendency to describe her experiences in imaginative, indirect, and metaphoric proverbs.

In line with Bugrah, Wojcik, and Gupta (2011), the findings showed how the client's mental health was influenced many factors, shaping distress and vulnerability in the context of cultural identity and cultural congruity. According to the stress vulnerability model of schizophrenia (Birchwood & Jackson, 2001), an underlying vulnerability to schizophrenia can be activated by psychosocial stress; even little social stress can activate symptoms for people with a high vulnerability. However, by assisting Dilbar in constructing a life story based on her paintings, the therapist could help her frame her problems in a cultural context that in turn shaped a dynamic continuity in which her internalized experiences could transform and become externalized in relation to the therapist, the activities, and the external world in general. By constructing her life story, Dilbar also developed mastery and coping skills that made her less vulnerable. The findings confirm Pratt, Gill, Barrett, and Roberts (2006) who stated that improved coping ability and competence in social and vocational environments reduce the vulnerability to stress.

Using proverbs provided an opportunity for the therapist to enter the client's secluded and hidden world and to a certain extent gain insight into the client's suffering, personal problems, and cultural conflicts. Metaphors are useful, according to Kielhofner et al. (2008), when people are struggling to understand complicated and painful events that are beyond their comprehension. They also imply how such problems can be solved or overcome. In addition, the findings illustrated how the use of the painted pictures and the proverbs opened a door for enriched narratives about the self that led Dilbar to be more motivated, active, and involved in the therapeutic process. This is consistent with Al-Krenawi (2000) showing that mental health care providers must understand their non-Western clients' way of communication such as the use of metaphors and proverbs rather than a literal and concrete description. Moreover, Al-Krenawi (2000) argues that proverbial expressions are "effective in therapeutic communication because they cloak anxiety-laden, raw conflicts in more abstract, and therefore more acceptable symbolic form" (p. 2).

### **Methodological discussion and reflection**

A case study was appropriate for the purpose of the present study because it (a) was a descriptive method, (b) was narrowly focused, (c) was highly detailed, (d) combined objective and subjective data, and (e) was process oriented (Dyer, 1995).

A narrative analysis was also shown to be relevant for this study because it allowed the authors to

uncover the unique attributes of the case by examining the transformative and long duration traits of the therapy process. Narratives play a significant role in helping to illustrate analysis portrayed by the client as a subject of lived experiences and combined "a succession of incidents into a unified episode" (Polkinghorne, 1995, p. 7). It was also a relevant tool for understanding the subtle meanings and values depicted in the painted pictures and metaphoric proverbs, as well as the significance of culture for the client's self. A narrative portrays the self as the subject of a myriad of experiences in the form of a story-like account (Sparrowe, 2005). Dilbar's narrative revealed how herself was awakened and how it gradually changed and transformed. Metaphorical proverbs and paintings are considered as valid sources and as analytical devices for gaining insight (Carter, 1990). The proverb metaphors were used in a similar way to the paintings for acquiring insight about the participant's thoughts and feelings regarding her life. They made it possible to unveil the client's deeper conceptions, grounded in her lifeworld experiences.

The data collection occurred when the first author was working as an occupational therapist in an outpatient rehabilitation setting. The first author and the participant were thus engaged in a collaborative relationship in a natural setting in the participant's own context. The first author's collaborative approach as an insider may have several advantages concerning the trust and confidence in the trainee-client relationship. The cultural affiliation between the first author and the client and her family contributed to an early collaborative stance that in turn could generate comfort and trust in therapy (Pooremamali et al., 2011b). On the other hand, this type of insider approach might jeopardize professional boundaries, distancing, and roles. Being aware of this problematical situation, the first author wrote down the experiences, reflections, insights, and questions and discussed these on a weekly basis with the multidisciplinary team. The first author's insider approach may also have influenced the analysis and interpretation of the previous collected data. All the authors were, however, aware of this dilemma, and the three co-authors were thus active in the analysis and in developing alternative interpretations and in developing the plots into a holistic story. Making this research 4 years after the therapy took place was also an advantage, being as the first author had achieved a distance that reduced the risk of a professional judgment taking precedence over research findings.

In order to satisfy demands for rigor, the authors followed the criteria of credibility, transferability, dependability, and confirmability as proposed by

Lincoln and Guba (1985). The story was returned to the client for verification. She was asked to review the core story and was free to make corrections or develop any part of the story. She verified the core story without any changes, which supported the study's *credibility*. Furthermore, a thorough description of methods, as is the case in this study, serves as an audit trail by which the reader can assess the credibility. Credibility was also established by the authors having several sessions, where the aim was to critically evaluate if the process of emplotting gave full justice to the data and reflected the participant's experiences. The rich description of the research methods and processes also makes it possible for the reader to assess the *transferability* of the findings to another situation. But since this was a case study, the transferability must be seen as being limited. The *dependability*, which means that the study can be replicated with the same or similar participants in the same or another context, is difficult to assess because the case study was limited to one client. The *confirmability* was strengthened by the fact that the first author presented preliminary findings at seminars and discussion groups.

This case study includes detailed descriptions of the client's lifeworld that warrants some ethical reflections. The client's approval of the study was obtained both at the time of therapy and when the study was made. That was to ensure that she did not see differently upon her previous consent 4 years later when this study was conducted. Furthermore, in order to safeguard the client's identity some details such as type of and location for activities and the client's name were disguised. The involvement of family members in the therapy inferred a significant dilemma in terms of the client's right to autonomy and protection of her privacy. In Western occupational therapy codes of ethics, it is clearly stated that to protect a client's autonomy, direct or indirect limitation of family involvement is justified (American Occupational Therapy Association, 2010; Pearmain, 2010; Swedish Association of Occupational Therapists, 2005). Thus, involving the family in the therapy was an act of balancing bicultural aspects, and for each decision the ethical implications were carefully considered.

## Recommendations

The findings from this study have some important clinical implications for occupational therapy but also for psychiatric treatment and rehabilitation in general. The life of the Turkish-Swedish young woman strongly reflected a collectivistic culture and previous treatments that had ignored this led to detrimental consequences. A conclusion from

Dilbar's course of illness and treatment is that the therapist must give explicit attention to the surrounding cultural and societal contexts that shape the immigrant clients' experiences, abilities, interpersonal relationships, interactions, and sense of self. The therapist needs to be open-minded and incorporate several aspects of the culture into the therapy in such a framework to create a new dynamic within the client's cultural contexts. Secondly, the therapist must adopt many strategies and techniques, modify them if necessary and thereby create an innovative and individualized intervention where the focus is on both the client and the larger socio-cultural contexts. Interventions that, for example, aim for an interdependent life must incorporate a flexible view of the concept of autonomy and be compatible with the cultural context of the client by including the family members in the process of intervention. This study also has implications for further research. The presented clinical case clearly demonstrated how the complexity of the phenomenon of culture needed to be considered critically. There is also a need for additional intra- and cross-cultural research regarding Middle Eastern clients in occupational therapy. Although this study provided insight into several issues, it could not address, for example, the relationship between a person's degree of acculturation and aspects such as an interdependent/independent self, occupational satisfaction and capacity, and perceptions of health and well-being. In addition, the intervention used in the current case needs to be tested in several cases and perhaps in diverse field settings in order to assess its transferability. Further research in this area would thus benefit the development of culturally adjusted programs.

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## Notes

1. In Islamic *sharia* legal terminology, a *mahram* is an unmarriageable kin with whom sexual intercourse would be considered incestuous, a punishable taboo. Islamic normative tradition *sharia* has classified opposite-sex relationships within two categories: Lawful *mahram* and unlawful *na-mahram* and has developed rules for how men and women may associate in daily life (Ask, 2005; Rashidian, 2005; Yasmeen, 2001). Despite the fact that *mahram* is not shaped as a common law or statute in the Middle Eastern health care system, it has an enormous consequence on ethical codes of behavior that regulate personal, interactional, and interpersonal aspects of the patient and health care provider relationship in the health care system.

In previous research (Pooremamali et al., 2011b) it was shown that Middle Eastern clients with mental disorders considered their relationship with a therapist as a *mahram*.

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