Wits School of Arts

Drama for Life

Master's Research Report

A Narrative Approach: Perceptions of Mental Health Services and The Role of Creative Arts Therapies in South Africa's Coloured Communities

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Research essay submitted to the University of the Witwatersrand in partial fulfilment of the requirements of the Master of Arts in the field of Drama Therapy.

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I want to express my deepest gratitude to my parents and sister for their unwavering support, encouragement, and love throughout this journey. Your belief in me has been my most significant source of strength. To my Johannesburg family, thank you for being my home away from home, for the laughter, the care, and the constant reminders that I am never alone in this process.

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Abstract

This research examines perceptions of mental health services and the role of creative arts therapies within South Africa's Coloured communities using a narrative approach. Employing qualitative narrative inquiry, the study gathers personal stories from professional mental health workers in the Cape Flats area of Cape Town. Narrative inquiry systematically studies how people experience the world and construct meaning through stories. Through the semi-structured online interviews, the research aimed to uncover nuanced perspectives on mental health and creative arts therapies. Data was collected through audio recordings, with written consent from participants, and analysed using thematic analysis. Theoretical analysis is informed by critical race theory to examine how historical and contemporary inequalities influence mental health experiences. Thematic analysis (Braun & Clarke, 2006) was employed to identify and interpret narrative patterns and themes, ensuring adherence to ethical practices, including informed consent and confidentiality.

Keywords

Mental Health Services, Critical Race Theory, Drama Therapy, Creative Arts Therapies, Coloured Communities

Definition of terms

Mental Health: The National Mental Health Policy Framework and Strategic Plan 2023–2030 defines mental health as a state of psychological well-being that enables individuals to manage life's challenges, fulfil their potential, learn effectively, perform well at work, and positively engage with their communities. Mental health is a crucial aspect of overall health and well-being, extending beyond the mere absence of mental illness.

Mental Health Services: The South African Mental Health Care Act of 2002 defines Mental Health Services as any health care service provided to individuals with mental illness, intellectual disability, or any mental health condition. These services include assessment, treatment, rehabilitation, and care, provided in a manner that respects the rights and dignity of patients.

Mental Health Professionals: In this research, mental health professionals are defined as individuals engaged in psychological work, which includes psychologists, social workers, and educators who incorporate psychological principles into their practice. Psychological work refers to activities that involve assessing, supporting, or enhancing individuals' mental and emotional well-being, whether through formal therapeutic interventions, counselling, or structured educational support (WHO 2022).

Creative Arts Therapies: The Health Professions Council of South Africa states that Arts Therapy is the therapeutic use of drama, movement, art, and music to open up avenues for change. The Arts allow people to engage with and find meaningful ways to explore their multicultural and diverse social realities as part of their therapy (HPCSA 2023:1).

Drama Therapy: For this study, I define Drama Therapy as a form of therapy where drama serves as the primary medium. It is a structured therapeutic space that enables the client to express and explore their own thoughts and experiences in any way they find to be comfortable. It is a form of therapy that values the individual and shapes its practice around the client. It is not a one-size-fits-all approach. In Drama Therapy, one learns and grows through doing (Jones 2007; Jennings et al. 2005).

Coloured Communities: are groups of individuals identified as Coloured who share everyday racial and cultural experiences and histories. These communities have unique social structures and cultural practices shaped by their diverse heritage and historical experiences under South Africa's racial segregation policies (Adhikari 2004, 2006, 2009; Khan 2018).

List of abbreviations

CRT: Critical Race Theory
HPCSA: The Health Professions Council of South Africa
DT: Drama Therapy
MHCA: Mental Health Care Act
NGO: Non-Profit Organization

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Chapter One:

Introduction and background to the study

1.1 Background of the study

Upon arrival at the Apartheid Museum in Johannesburg, South Africa, visitors are met by two entryways. One door read “Blankes”, translating to white, and the other “Nie-Blankes,” meaning not white in English. That entrance illustrates the everyday reality of what it was like living in Apartheid. Racial classification was the foundation of all apartheid law (Christopher 2002). Today, South Africa classifies its population into four racial categories: Black African, White, Indian, and Coloured (Tewolde 2024). The Apartheid regime established the existing four racial categories in contemporary South Africa through the Population Registration Act No. 30 of 1950 (Christopher 2002). According to the statistics, South Africa has five racial categories: Black African, Coloured, White, Indian/Asian, and Other. Stats SA, short for Statistics South Africa, is the country's national service for official statistics. They achieve this by conducting official surveys and censuses on the population, economy, and social issues. According to the Census 2022, our country's population consists of approximately 81.4% Black African individuals, 8.2% Coloured individuals, 7.3% White individuals, 2.7% Indian or Asian individuals, and 0.2% belonging to other groups.

The lasting social and economic inequities, which are evident along racial lines, make South Africa one of the most unequal societies globally. These inequalities in housing, healthcare access, health, and socioeconomic status increase the risk of poor mental health (Harriman, Williams, Morgan, Sewpaul, Manyaapelo, Sifunda, Mabaso, Mbewu, and Reddy 2021). According to Sapiens Labs’ Mental State of the World Report, in 2023, South Africa had the 2nd highest percentage of individuals experiencing stress or distress out of 71 countries. South Africa experiences a high prevalence of mental health illnesses, influenced by a range of factors such as poverty, unemployment, trauma, HIV/AIDS, and a legacy of political and social turmoil (Nguse &Wassenaar 2021; Shisana, Stein, Zungu, & Wolvaardt 2024). The country's high rate of trauma, which includes widespread exposure to violence and abuse, significantly increases the risk of developing mental health illnesses (Kim, Nyengerai, & Mendenhall 2020).

According to Kaminer, Du Plessis, Hardy, & Benjamin (2013), it is estimated that 98.9% of young people on the Cape Flats have witnessed violence, and 40.1% have been victims of it within their communities. The Cape Flats community is one of the oldest communities that is characterized by its high level of violence, which is primarily due to gang activity in this community (Kinnes 2017). Chauke & Malatji (2021) emphasize that the youth on the Cape Flats turn to violence as a result of a lack of parental care and the prevalence of drug use. Additionally, Artz, Jackson, Rossiter, Nijdam-Jones, Géczy, & Porteous (2014) argue that young people from environments marked by domestic violence often experience mental health challenges.

The media coverage of the Cape Flats community is flooded with depictions of violent gangsters and drug users. On News24, one will find bold headlines such as 'What freedom?' Gangs, poverty, and death - life is a 'nightmare' for many Cape Flats residents, 'Three arrested for the murder of a 6-year-old boy from Hanover Park in Cape Town', 'Mommy Mommy!': Woman hides under her bed as gunshots ring out in Manenberg gang war (Solomons 2022; News24 2023; Solomons & Evans 2022). Stoffberg (2023) explains that previous research on the Cape Flats has mainly focused on its challenges, highlighting the adverse conditions in the area. However, little attention is given to the many athletes, dancers, musicians, artists, and other talented creatives who live there. This community, which is depicted as violent and ruthless, is also rich in culture.

The Cape Flats community has forged its language, Afrikaaps. It flourishes in the arts, birthing world-renowned musicians like Jonathan Butler and crafting theatre productions that capture its essence, such as Marc Loitering's *Aunty Merle*, which fills the Baxter Theatre. Its cultural impact continues to expand, with groundbreaking television productions like *Beaula: Queens van die Kaap* bringing the colour of Cape Drag culture into homes nationwide. The show is presented in Gayle, a mix of English and Afrikaans slang popularized by the Cape Coloured drag scene in the 1950s. The Cape Flats community transcends the violent imagery often associated with it, embodying a deep resilience, creativity, and cultural richness that pulses through its music, storytelling, and everyday survival.

Gamieldien et al. (2024) note that there is an increasing body of research on how people in low- and middle-income countries (LMICs), such as South Africa, experience personal recovery in mental health services (De Wet & Pretorius 2020). However, there is still a

limited exploration of their lived experiences and the contextual challenges that shape their recovery journey. Little focus has been placed on the social and economic difficulties that mental health service users face in their communities. Understanding these challenges is crucial to developing more effective recovery support and services that meet their needs (Gamieldien et al. 2024).

The South African government has made commendable strides in prioritizing access to mental health care through legislation and policy, as seen in the Mental Health Care Act of 2002 and the National Mental Health Policy Framework (Shisana et al. 2024). However, a significant gap remains between policy development and implementation. The absence of a sustainable funding model continues to hinder progress, as there is no apparent financial framework to support the execution of these policies and plans (Shisana et al. 2024). As a result of these challenges, mental health services remain underfunded and difficult to access, especially in historically marginalized communities such as the Coloured communities of Cape Town. Given the high levels of violence, trauma, and socioeconomic hardship experienced in areas like the Cape Flats, it is crucial to examine how mental health policies translate into lived realities.

My research will employ a qualitative narrative inquiry approach (Clandinin & Huber 2010), gathering personal stories and experiences from four professional mental health workers working in or with the Coloured communities in the Cape Flats, Cape Town, and using semi-structured interviews to understand the nuanced perspectives of individuals regarding mental health services and creative arts therapies, specifically Drama Therapy. The theoretical framework will draw on critical race theory to analyse how historical injustices and contemporary inequalities could shape mental health experiences and perceptions in Coloured communities. These frameworks will provide a lens to critically examine the intersection of race, history, and mental health in South Africa.

1.2 Rationale

The National Mental Health Policy Framework and Strategic Plan for 2023-2030 aims to support mental health at all stages of life, emphasizing how social factors influence mental well-being and the shared responsibility of various government departments and stakeholders

(Department of Health 2023). The policy discusses the importance of making mental health services accessible at all levels of healthcare, providing care in proximity to where people live and work. Community resources should be utilized whenever possible, ensuring fair access for everyone, regardless of their location, financial situation, or identity. Cultural perspectives on mental illness should be respected as long as they uphold human rights and do no harm. People with mental health conditions have the right to practice their religion and spiritual beliefs. Services should be tailored to meet the individual's needs, the severity of their illness, and the level of their disability. In the policy, one can also find a list of human mental health resources available in South Africa, including psychologists, social workers, and other relevant professionals.

The Sustainable Development Goals, also known as SDG, Country Report 2019 states that one of the four pillars on which the SDG stands is the determination to end poverty and hunger, in all their forms and dimensions, and to ensure that all human beings can fulfil their potential in dignity and equality and in a healthy environment (Statistics South Africa 2019)

South Africa's Mental Health Care Act No. 17 of 2002 was established to ensure the rights of individuals with mental health illnesses and aims to improve mental health care services (Ramlall 2012). It outlines patients' rights to treatment, privacy, and protection from discrimination. The Act also regulates involuntary treatment and defines the responsibilities of healthcare providers, law enforcement, and community organisations in mental health care. Yet, despite the Mental Health Care Act, our country still witnessed the Life Esidimeni tragedy in 2015 (Dhai 2018).

In October 2015, a member of the Executive Council of Health in the Gauteng province announced the termination of a 40-year contract between the Department of Health and Life Esidimeni (Dhai 2018). Life Esidimeni was a long-term psychiatric care hospital that cared for approximately 200 mental health care users. The Gauteng Department of Health planned to transfer mental health patients to NGOs and other psychiatric hospitals as part of an effort to move away from institutionalized care and instead promote community-based care, while also seeking to reduce costs (Dhai 2018). However, an investigation by the Office of the Health Ombud revealed that 27 NGO facilities where patients were transferred were operating without a licence. They also noted that during transfer, patients were transferred inhumanely. Some patients had their hands and feet tied throughout the move, others moved

without their families knowing, and some were transferred without their clinical records. The overall change in providers resulted in the death of 144 mental health care patients (Dhai 2018).

The Life Esidimeni tragedy highlights the importance of studying mental health care, particularly in areas like the Cape Flats, where people often lack adequate support. Although South Africa has policies that stipulate mental health care should be accessible and equitable for everyone, many communities continue to struggle to obtain proper care (Maphumulo & Bhengu 2019). This research will examine their experiences to gain a deeper understanding of these challenges. It will also explore whether Drama Therapy could be a valuable means of supporting mental health in this community. By examining both the experiences of mental health workers and the potential of Drama Therapy, this research aims to discover alternative approaches to support mental well-being in the Cape Flats, Cape Town.

In exploring these challenges, it is also essential to consider the cultural expressions and coping mechanisms embedded within the community's everyday life, such as the songs and stories that reflect collective experiences and resilience. There was a song that my cousin and I always used to sing growing up called 'Pom Pom', which was shortened from *"Jou hare kan nie pom pom nie",* which loosely translates to *'you can't tie your hair'* or *'your hair can't go into a ponytail'.* Emo Adams performed his version of the song on the television show Expresso, referencing both *Kroes* hair and a GHD, which is a hair-straightening iron. This song actively perpetuated the idea that long and 'gladde hare', straight hair, is the most desirable. This is a song still sung today, originating from an era when women had to undergo the pencil test. During Apartheid, a pencil was stuck in one's hair to separate people based on their race, identifying whether they were White, Coloured, or Black (Morey & Wilbraham 2003). The song's upbeat and humorous tone piques my curiosity about the coping mechanisms historically used by Coloured communities to deal with past traumas, as well as those they employ today. Could Drama Therapy align with the cultural practices of these communities and serve as a container for their already internalized coping mechanisms?

This research aimed to explore perceptions of mental health services and assess the effectiveness of creative arts therapies, specifically Drama Therapy, in this context. The goal was not to develop a new intervention, but to evaluate existing services and approaches within the community and elsewhere. By identifying current practices and considering how

different methods could be integrated, the study sought to recommend interventions best suited to community needs. Adopting a narrative approach, the research also examined the beliefs, attitudes, and barriers that shape help-seeking behaviours among South Africa's Coloured communities in the Cape Flats, providing insights to inform culturally appropriate solutions.

1.3 Question

How do mental health professionals working with Coloured communities living in the Cape Flats, Cape Town, perceive the cultural, structural, and practical factors influencing mental health services and the potential role of creative arts therapies, particularly Drama Therapy, in these communities?

Sub Questions:

1. What are the key mental health challenges and strengths observed within Coloured communities?
2. What cultural factors influence mental health perceptions, help-seeking behaviours, and engagement with mental health professionals?
3. What are the structural and systemic barriers to accessing mental health services in Coloured communities?
4. How do mental health professionals view the potential for creative arts therapies, particularly Drama Therapy, within these communities?

1.4 Aims and Objectives:

Aims:

1. To explore how mental health professionals perceive the challenges, strengths, and cultural dynamics that shape mental health care in Coloured communities.
2. To investigate the systemic and structural barriers that impact access to mental health services.
3. To examine attitudes towards creative arts therapies, particularly Drama Therapy, in mental health interventions.

Objectives:

- Conduct workshops with a group of 4 mental health professionals working with Coloured communities from Cape Town to gather detailed professional accounts of their experiences with mental health services.
- Analyse the collected narratives to identify common themes and barriers regarding the use of mental health services and creative arts therapies.
- Assess mental health professionals' familiarity with and attitudes towards Drama Therapy as a therapeutic tool.
- Provide recommendations on how creative arts therapies, particularly Drama Therapy, could be adapted or introduced within these communities.

1.5 Theoretical Framework

Critical Race Theory:

Critical Race Theory (CRT) originated in the legal field in the 1970s in response to the slow progress of traditional civil rights litigation, which struggled to achieve significant racial reform (Taylor 1998). There are many founders of Critical Race Theory, such as Derrick Bell and Kimberlé Crenshaw (Taylor 1998). Kimberlé Crenshaw, a pioneer of Critical Race Theory, explained it as a method for confronting a history of white supremacy. Critical Race Theory rejects the notion that the past is irrelevant and that the laws and systems derived from that past are disconnected from it (Crenshaw et al. 1995). CRT questions the idea that white individuals are the universal norm and bases its principles on the unique experiences of people of colour. This approach emphasises that understanding racial dynamics requires acknowledging the social and lived realities of racial oppression, especially how current inequalities are linked to historical practices of racial exclusion (Taylor 1998).

Critical Race Theory helps us understand race by looking at people's real-life experiences. The stories we share shape how we perceive and respond to our racial identity. This theory suggests that race is not solely determined by biology, but also by the social factors that define racial groups. If we view race primarily as a social construct rather than as just a

matter of biology, we gain a more complete understanding of its significance and the impact of individual experiences (Du Preez 2021).

As the researcher who identifies as a Coloured woman, I chose CRT because it provides a nuanced understanding of how historical and contemporary racial injustices impact mental healthcare experiences and access among South Africa's Coloured communities. CRT's emphasis on lived experiences and the social construction of race allows for a comprehensive exploration of the complexities involved in perceptions of mental health and creative arts therapies. By employing a narrative approach, this study aims to amplify the voices and experiences that are often marginalized within mainstream healthcare discourses. CRT encourages an examination of how systemic inequalities and cultural factors intersect to shape health-seeking behaviours and perceptions of efficacy in treatment modalities

1.6 Chapter Summary

Chapter 2 presents a literature review, examining key themes in Drama Therapy, the complexities of Coloured identity, and the role of stakeholders in South Africa's mental health landscape. Chapter 3 outlines the study's methodology, detailing the qualitative approach, participant selection, data collection, and analysis process. Chapter 4 presents the results and discussion, structured into four themes: *Cultural Identity: A Bridge or a Barrier?*, which explores how cultural identity influences perceptions of mental health; *Understanding Community Pressures*, which examines societal expectations; *The Roadblocks Faced by Mental Health Practitioners*, which highlights systemic challenges in providing care; and *Drama Therapy in Action: Principles at Work*, which showcases how Drama Therapy is applied in practice. Finally, Chapter 5 concludes the study by synthesizing key findings and reflecting on their significance within the broader context of mental health and Drama Therapy in South Africa.

Chapter Two:

Literature Review

2.1 Drama Therapy

For this study, I define Drama Therapy as a form of therapy where drama serves as the primary medium. It is a structured therapeutic space that enables the client to express and explore their own thoughts and experiences in any way they find to be comfortable. It is a form of therapy that values the individual and shapes its practice around the client. It is not a one-size-fits-all approach. In Drama Therapy, one learns and grows through doing (Jones 2007; Jennigs et al. 2005).

2.1.1 The History of Drama Therapy

Jennings, Cattanach, Mitchell, Chesner, Meldrum & Nfa (2005) explain that Drama Therapy as a profession emerged in Britain in the 1960s. It originated from practices in drama education, theatre in education, and remedial drama in the early 1960s, where a shift occurred, and people began to question traditional institutions such as psychiatry. At this time, arts therapy groups started to emerge in Britain and Europe. A belief began to grow in Europe that new creative and educational approaches could transform society (Jennings et al. 2005).

One key figure in the development of Drama Therapy was Peter Slade (Jennings et al. 2005). He strongly advocated for the use of drama as a form of self-expression for children. He encouraged parents and teachers to truly listen to children rather than impose control, a revolutionary idea at the time (Slade 1995). In education, Dorothy Heathcote introduced drama as a means of exploring knowledge (Heathcote & Bolton 1994). She was unlike any other teacher of her time. Her teaching method involved being in the process of learning alongside her students. She would actively engage in the drama herself, playing roles alongside her students to deepen their learning. She believed that combining drama with reflection could foster significant personal and intellectual growth (Heathcote & Bolton 1994).

Drama Therapy as a distinct practice began to take shape through the work of Sue Jennings, who founded the *Remedial Drama Group*. This group applied drama techniques from

education in therapeutic settings. The group evolved into the *Remedial Drama Centre* in London, which was the first institution dedicated to training and practicing Drama Therapy with individuals who had special needs. In 1970, it was rebranded as the *Drama Therapy Centre,* and in 1972, it further expanded into a private consultancy offering training and group therapy for both adults and children (Jennings et al. 2005).

In 1977, Drama Therapy was recognized within the arts therapy community as a distinct practice, separate from psychodrama. This led to its inclusion in academic settings, with institutions such as Hertfordshire College of Art and Design, Ripon, and York St John, as well as South Devon Technical College, launching diploma courses in dramatherapy between 1977 and 1980. The field continued to grow, and in 1988, the Institute of Drama Therapy was established, offering a diploma with a strong theatrical focus. Today, numerous postgraduate training programs in Britain are dedicated to Drama Therapy (Jennings et al. 2005).

Qhobela (2015) explains that Drama Therapy as an academic field in South Africa is relatively recent. Formal training to become a Drama Therapist began at Drama for Life, also known as DFL in 2014 (Rowland 2014). Currently, DFL offers the only accredited Drama Therapy training program in Africa (Nebe 2016), which includes an Honours degree, a Master's degree (with both coursework and a research component), and an internship. The internship is facilitated by DFL through Wits Plus and is recognised by the Health Professions Council of South Africa, also known as the HPCSA. Once an intern completes this internship and meets the requirements, they can then register with the HPCSA as a qualified Drama Therapist.

Mayson (2020) explains that before training became available in South Africa, many first-generation South African Drama Therapists had to study abroad and adapt their learning upon returning home to South Africa. These therapists had to readjust their training to resist "neo-colonial impositions" (Meyer 2014:5), which could make Drama Therapy feel inaccessible or ineffective in the local context. To address this challenge, Drama for Life incorporates indigenous knowledge systems, critical reflexivity, critical pedagogy, and social justice into its curriculum, ensuring that Drama Therapy is relevant to South Africa's context (Nebe 2016).

2.1.2 What is Drama Therapy

The terms ‘drama’ and ‘theatre’ are two terms that are closely related. Many people may use these two terms interchangeably; however, there is a difference between them. The misconception of using the term drama synonymously with theatre can create expectation and unwanted anxiety when it is used in Therapy.

Davis & Behm (1987) explain that drama is something that is done, while theatre is something to gaze upon. Drama and theatre exist on a continuum (Davis & Behm 1987). Process-oriented activities, such as exploring, sharing, crafting, presenting, and assessing, are on one end, and performance-oriented activities on the other. The primary difference between the two ends lies in the contrast between process and product. (Davis & Behm 1987; Mages 2016).

When feeling unhappy, people often choose to see a show at the theatre, play music, sing, or participate in their favourite sports. We describe these activities as ways to lift our spirits, help us feel better, or distract us from our problems. These expressions suggest that such activities can bring about a positive change in our mood or outlook.

This relationship between personal expression and the continuum of drama and theatre highlights how engagement in either end of the spectrum—whether through creative exploration or public performance—can impact well-being. Activities like playing music, singing, or participating in theatre not only serve as artistic outlets but also function along the process-product continuum described by Davis & Behm (1987). Engaging in the process-oriented aspects, such as improvisation or rehearsal, allows for personal growth and emotional release, while the product-oriented aspects, such as staged performances, offer opportunities for validation and communal experience. Both ends, though different in focus, provide significant emotional benefits, demonstrating how the continuum is not just a theoretical model but is intimately connected to real-life experiences and well-being.

Drama Therapy fuses Drama and Therapy, but it is more than just a simple combination. This integration forms a distinctive approach that offers unique ways to support individuals, incorporating elements and techniques from both areas (Davis & Behm 1987).

There are several definitions for Drama Therapy. Emunah (1994:3) refers to Drama Therapy as “the intentional and systematic use of drama/theatre processes to achieve psychological

growth and change. The tools are derived from drama, the goals are rooted in psychotherapy. Jones (2007) explains that, to him, Drama Therapy is a form of therapy that uses drama and performance to support emotional healing and personal growth. It provides a structured space where individuals can explore their feelings, challenges, and life experiences through creative expression. In engaging with role-playing, storytelling, and group interactions, clients can reflect on their struggles and develop new ways of understanding and addressing them. The process connects clients with their inner thoughts and emotions through real-life situations, helping them form healthier perspectives and develop more effective coping strategies.

In the context of South Africa, Art therapy is a relatively new and emerging form of therapy. The Health Professions Council of South Africa states that Arts Therapy is the therapeutic use of drama, movement, art, and music to open up avenues for change. The Arts allow people to engage with and to find meaningful ways to explore their multicultural and diverse social realities as part of their therapy (HPCSA 2023:1). This spectrum of arts therapies provides various ways for self-expression and healing, reflecting a commitment to addressing multicultural and individual needs.

Drama-based practices have long been used worldwide to support health and healing, and in South Africa, protest theatre is a powerful example. Plays like *Woza Albert* and *Nothing but the Truth* brought the realities and feelings of black South Africans during Apartheid to life for audiences. The establishment of the Truth and Reconciliation Commission, also known as TRC, reflects a national effort to use drama-based storytelling as a tool for healing. The TRC's hearings provided survivors with a platform to share their stories—a process deeply rooted in African oral tradition and crucial for their healing (Corry & Blanche 2000). Because storytelling is such an integral part of African culture, Drama Therapy holds special significance in South Africa, resonating with the traditional ways people understand and cope with trauma (Oamen 2011). Ultimately, storytelling lies at the heart of both drama and theatre, connecting people through shared narratives and emotional journeys. Whether as part of a creative process or a polished performance, storytelling enables participants and audiences alike to reflect on experiences, explore feelings, and forge connections with others. This powerful act of sharing stories is what makes drama a transformative part of both individual well-being and collective culture.

South Africa is a diverse nation, meaning that there are many different cultural approaches to addressing mental health issues. Seleme (2017: 9) states that “culture appears to be a barrier for some individuals to access therapy because their culture may be marginalized in the process of fostering well-being.” One cannot ignore the role of culture in a therapeutic environment, as disregarding it may lead people to feel alienated within the therapeutic space. Drama Therapy, however, can incorporate different cultures while achieving therapeutic goals (Makanya 2014). Drama Therapists can encourage participants to share personal stories and traditions from their cultures and integrate these elements into therapeutic activities. Jennings et al. (2005) explain that Drama Therapists work with both individuals and groups, offering support in various settings. Arts therapists work with individuals of all ages, including children, teens, and adults (Jones 2007).

2.1.3 Research on Drama Therapy

Korde, Šuriņa, & Mārtinsone (2023) analysed 395 journal articles published between 1949 and 2022. In their analysis, it was revealed that there was a steady increase in Drama Therapy research. Early publications focused on foundational theories and concepts, while later studies explored therapeutic interventions for different client groups and systematic reviews. Systematic reviews are recognized for their high level of evidence, indicating that the academic field of Drama Therapy is maturing (Ratnani et al. 2023). Korde, Šuriņa, & Mārtinsone (2023) suggest that systematic reviews are among the most frequently referenced works, demonstrating their role in helping researchers navigate and understand the field of Drama Therapy.

Findings also indicate that only a small number of researchers have multiple publications in the field (Korde, Šuriņa, & Mārtinsone 2023). This may suggest that many Drama Therapists do not continue academic research after their initial studies, possibly due to limited national support for doctoral programs. In recent times, the most influential researchers in Drama Therapy are often affiliated with universities, professional associations, and academic journal editorial boards, underscoring the importance of a strong research infrastructure (Korde, Šuriņa, & Mārtinsone 2023). The most prominent countries in Drama Therapy research are the United States, Israel, and the United Kingdom, where the field originated (Korde, Šuriņa, & Mārtinsone 2023). Drama Therapy research spans multiple disciplines, including medicine, psychology, healthcare, the arts, humanities, and social sciences. However, Korde, Šuriņa, &

Mārtinsone (2023) suggest that greater interdisciplinary collaboration could help establish a more unified language for the discipline. Currently, the most urgent research topics focus on mental health challenges, particularly depression, anxiety, and suicide prevention (Letrondo et al. 2023).

Within the South African context, Hutton (2019) in her research establishes that creative arts therapies have proven to be effective interventions for working with trauma among children in South Africa, with reference to Pretorius & Pfeifer (2010) showing that art therapy significantly alleviated symptoms in young girls who had experienced sexual abuse. Arts therapy can support children dealing with trauma within the South African context (Hutton 2019; Pretorius & Pfeifer 2010).

Drama Therapy has been used in the South African context. In Hutton's (2019) literature review, she advocated for the use of role-play, one of Jones' (2007) nine core principles of Drama Therapy, which utilizes the role of the hero as a trauma intervention for children. It is also mentioned that South Africa faces a critical shortage of mental health resources, particularly for children. The mental health system is overwhelmed, leading to burnout among many professionals (Hutton 2019). Busika (2015) examined how storytelling, specifically the isiXhosa tradition of Intsomi, can be used in Drama Therapy to build resilience among urban South African children. The application of Drama Therapy is evident in South Africa, where role-play and storytelling are being recognized as effective interventions.

Drama therapy research in South Africa encompasses a range of approaches, including techniques, therapist training, literature reviews, and various research methodologies. Studies like Seleme's (2017) incorporate traditional cultural practices, such as the umgidi ritual, into Drama Therapy to create culturally relevant therapeutic spaces. Cloete's (2020) work examines the role of Drama Therapy in providing psychosocial support to out-of-school youth in Namibia, utilizing developmental approaches and thematic analysis. Research on therapist training, such as Mlangeni's (2019) feminist paradigm study, highlights gendered challenges and the role of feminist pedagogy in shaping practice. Literature reviews, such as Hutton's (2019) scoping review on trauma and role-play, critique theoretical assumptions and explore the potential of Drama Therapy in building resilience. Vilakazi's (2021) research on

father absence and child development examines how Drama Therapy can mitigate psychological and relational challenges in single-mother households.

Research methodologies in these studies include qualitative techniques such as interviews, focus groups, case studies, and practical Drama Therapy workshops. Studies by Mlangeni (2019) and Seleme (2017) rely on interviews with professionals and cultural experts, whereas Cloete (2020) and Orelowitz (2015) use focus groups and extended workshops to analyse the impact of Drama Therapy. Thematic and phenomenological analyses are standard, enabling researchers to interpret participants' experiences and identify emerging themes. Through these varied approaches, South African Drama Therapy research explores both theoretical and practical dimensions, addressing cultural relevance, gender dynamics, and psychological development. This growing body of research contributes to the field's evolution, demonstrating how Drama Therapy can be adapted to local contexts and specific community needs.

2.2 Understanding Coloured Identity in South Africa

Understanding Coloured identity in South Africa requires recognising that it is not a fixed or singular concept, but one that has been shaped by complex historical, political, and social forces. Scholars such as Adhikari (2004, 2006), Erasmus (2001), and Khan (2018) emphasise that Coloured identity is both ambiguous and contested, often positioned uncomfortably between imposed racial categories of the past and contemporary struggles for self-definition and belonging. Rooted in colonial and apartheid classifications, yet continually reinterpreted in the post-apartheid era, Coloured identity represents an ongoing process of negotiation that reflects both collective histories and individual agency. To make sense of this identity, it is necessary to consider its historical roots, the lived experiences of Coloured communities, and the ways cultural practices and political debates continue to shape how Coloured people understand themselves today.

2.2.1 History of Coloured Identity

Coloured identity within the South African context is a complex and evolving concept (Adhikari 2004). Historical, social, and political influences shape it. The idea of Coloured identity has become a subject of ongoing debate (Khan 2018; Adendorf 2016; Adhikari 2004,

2006; Erasmus 2001; Fisher 2008; Terrence 2011). The Coloured community has often found itself caught between different racial classifications. Khan (2018) states that Coloured identity was historically understood as a racial 'middle point‘ between what is constructed as white superiority and Black inferiority. Colouredness today remains an uncomfortable subject for interrogation. The construction of Coloured identity from the past has led to questions about self-identification and belonging in the present. (Adhikari 2004).

Historically, Coloured identity was shaped during colonial rule and the apartheid era, which was a time when racial classification played a central role in determining social and economic status in the country (Adhikari 2004). The category of ‘Coloured’ was recognised as a racial classification with the implementation of the Population Registration Act in 1950. In the Act, Coloured and Indian were then further categorised into subgroups such as Griqua, Cape Coloured, Malay, Indian, Other Asian, and Other Coloured (Khan 2018).

Adhikari (2004) notes that in the post-apartheid era, the concept of Coloured identity has evolved due to the occurrence of social and political changes. According to Adikari (2004) and Khan (2018:12), one of the factors that influenced the evolution of Coloured identity was the "greater freedom of association.” Meaning that people classified as Coloured under apartheid law now have more autonomy in choosing how they identify. The removal of the rigid racial classifications imposed by apartheid has allowed for more flexible and self-defined identities (Khan 2018). This does not mean that racial identities have ceased to exist; instead, they have become more dynamic, shaped by new social, cultural, and political realities. It is this ambiguity that has now led to the questioning of long-held beliefs about what it means to be Coloured (Khan 2018).

The discourse on Coloured identity unfolds not only within the Coloured community itself but also resonates among those who define themselves as distinct, reflecting more profound questions of belonging and otherness (Adikari 2004; Khan 2018). An example of this debate occurred on a radio talk show between the late political analyst Eusebius McKaiser and the then Secretary General of the African National Congress, also known as the ANC. McKasier (2015) responds to when the then African National Congress (ANC) Secretary-General Gwede Mantashe claimed that Coloured people should consider themselves as Black. McKasier responded by saying that Mantashe, or any person who is Black African, does not have the authority to dictate how Coloured communities should define themselves. The conversation around Coloured identity must be led by Coloured people (McKasier 2015).

McKasier (2015) further notes that identity is deeply rooted in shared histories and lived experiences. It is through these collective narratives of Coloured people that the Coloured identity is defined. He warns that when political identities are imposed from outside the community, it takes away the agency to critically engage with the complex moral and political questions tied to the history of Coloured identity (McKasier 2015).

One of the persistent issues within Coloured identity is the shame associated with its historical construction. Khan (2018:13) says that, "When shame is a result of who one is, rather than what one does, it becomes very difficult to move on from it…If it is your very existence that warrants shame, it would seem that the only end to that shame comes when you cease to exist.". Adhikari (2006) explains that during colonial and apartheid rule, white supremacist ideologies framed Coloured people as the unwanted by-products of racial mixing. Over time, many Coloured individuals then internalized these racist views and values and accepted racial mixing as the defining characteristic of Coloured identity (Khan 2018). Some Coloured individuals went as far as to distance themselves from Black Africans to maintain a sense of social superiority (Adhikari 2006).

Adhikari (2009) outlines three main approaches to understanding Coloured identity. The first is the essentialist perspective, which views people whose identity is Coloured as a distinct racial group created by racial mixing dating back to the first European settlers in the Cape. The second approach to understanding Coloured identity is called the Instrumentalist Perspective. This approach sees Coloured identity as being a political and social construct created by the apartheid government with the intention of dividing oppressed communities. This approach was influenced by Black Consciousness ideology, which argues that Coloured identity was imposed rather than naturally forming. The third approach to understanding Coloured identity is the Social Constructionist Perspective. This perspective asserts that Coloured identity is fluid and constantly evolving. It established that Coloured identity is shaped by historical, cultural, and political forces, but one must not forget that Coloured individuals also actively participate in defining and reshaping their identity. This research aligns with the social constructionist perspective, recognizing that the Coloured identity is not fixed but instead continuously redefined through lived experiences (Adhikari 2009).

Despite the end of apartheid, Coloured identity remains a contested issue (Adhikari 2009). Petrus and Isaacs-Martin (2012) argue that Coloured identity is often interpreted in simplistic

racial terms, burdened by negative stereotypes and a lack of explicit recognition within post-apartheid South Africa. Coloured identity remains in a state of liminality, caught between historical marginalization and the struggle for recognition in contemporary South Africa (Khan 2018). Many Coloured individuals say "first we were not white enough, now we are not black enough," highlighting how many Coloured individuals who identify as Coloured feel continuously excluded (Adhikari 2004). Ultimately, Coloured identity is not a static category but an ongoing process of negotiation. Understanding this identity requires acknowledging its historical roots, recognizing the agency of Coloured individuals in shaping their own narratives, and addressing the social and political challenges that continue to influence their sense of belonging in South Africa.

2.2.2 Cape Coloured

It has become evident in understanding Coloured identity that it requires one to acknowledge its historical roots, recognize the agency of Coloured individuals in shaping their own narratives, and address the social and political challenges that continue to influence their sense of belonging in South Africa.

Under the Group Areas Act of 1950, Coloured and Black people were forced out of communities like Sophiatown and District Six and relocated to townships (Adhikari 2006). In my research, I focus on a specific subgroup of Coloured individuals within a geographically defined community, the Cape Flats. Due to apartheid-era spatial planning, or better described as spatial apartheid, Coloured communities were forcibly separated, leading to fragmented communities that continue to struggle with connection and reconciliation (Khan 2018). However, even within these fragmented conditions, communities developed new forms of belonging through shared narratives. These narratives served both as sources of strength and as limitations, shaping how individuals understand themselves and their place in society (Trotter 2009). The discourse on Coloured identity unfolds not only within the Coloured community itself but also resonates among those who define themselves as distinct, reflecting more profound questions of belonging and otherness (Adikari 2004; Khan 2018).

The Cape Flats is a large suburban area in the Western Cape, comprising many neighbourhoods, including Manenberg, Bonteheuwel, Mitchell’s Plain, Lavender Hill, Hanover Park, Heideveld, Athlone, Belhar, and Elsies River, all of which form part of this area (Khan 2018). These places are still struggling with deep poverty, rampant

unemployment, and high levels of violent crime (Trotter 2019: 51). When looking at the literature of Coloured communities, one can find that most of the accessible literature is about gangsterism in the Cape Flats, drug or alcohol addiction (Khan 2018). However, there is little academic literature on the culture of the Coloured community living on the Cape Flats. At the same time, many online websites address what is considered a Coloured culture. Mclean (2024) took to the streets of Cape Town to ask people from the Coloured community, living in the Cape Flats, how they would define Coloured culture. One person said that to them it was, "Koeksisters and tea on a Sunday morning." Others said," Coloured culture is walking in slippers and socks on the beach," or " Seeing the sun out and immediately needing to do washing, and another saying, "It's the Klopse; it's definitely the coons." The Coloured community in the Cape Flats, defined by its own people, is a blend of light-heartedness, tradition, humour, and resilience.

2.2.3 The Arts in Coloured Communities

As stated above, much of the research on Coloured communities focuses on the negative aspects rather than the strengths of the community. On January 2nd, also known as 'Tweede Nuwe Jaar', the Cape Town Minstrel Carnival takes place in Cape Town. Minstrels fill the streets, dressed in bright colours, carrying colourful umbrellas or playing musical instruments. The day of the carnival takes place on January 2nd to celebrate a slave holiday (Inglese 2022). It's a day when Coloured individuals, many of whom were displaced from the city centre due to the Group Areas Act, symbolically return. They take over the city with their own unique sounds and colours as they visit significant community sites: the ruins of District Six, where many Coloured individuals trace their family histories; the Slave Lodge, where their ancestors were bought and sold; and the Bo-Kaap area, the heart of Cape Malay culture and heritage (Inglese 2022). The minstrels are also known as the Kaapse Klopse. As they make their way down the street of Cape Town, you might hear the song ' Daar kom die Alibama'. The lyrics to the song are:

Daar kom die Alibama, die Alibama die kom oor die see.
Daar kom die Alibama, die Alibama die kom oor die see.
Nooi, nooi, die rietkooi, nooi, die rietkooi is gemaak,
Die rietkooi is vir my gemaak om daarop te slaap.
Nooi, nooi, die rietkooi, nooi, die rietkooi is gemaak,
Die rietkooi is vir my gemaak om daarop te slaap.

Die Alibama, die Alibama, die Alibama kom oor die see.
Die Alibama, die Alibama, die Alibama kom oor die see.

Translation in English:

There comes the Alibama, the Alibama comes over the seas
There comes the Alibama, the Alibama comes over the seas
Girl, girl, the reed bed girl, the reed bed has been made
The reed bed has been made for me to sleep on it.
Girl, girl, the reed bed girl, the reed bed has been made
The reed bed has been made for me to sleep on it.
The Alibama, the Alibama comes over the seas.
The Alibama, the Alibama comes over the seas.

This song is not only sung during the Carnival, but it is also sung in schools. Hoberman (2008), in his book *Kaapse Klopse,* tells us the story behind the well-known song. In 1862, Cape Town was introduced to the musical style of African American minstrel troupes when the Confederate warship Alabama stopped by for supplies. The ship's enslaved people performed impromptu shows, which excited many locals, including recently freed slaves. The impact of this visit was later captured in the famous song (Hoberman 2008).

Something uniquely found in the Kaapse Klopse is *Ghoema* music. The *Ghoema* beat is the basic rhythm and pulse of *Ghoema* music. Gregory (2018) states that Ghoema music is challenging to notate with Western music notation because it features subtle variations and accents, and it doesn't fit neatly into simple patterns. The word ghoema is related to the East African word 'ngoma,' which means 'song,' as well as to 'gora,' the name of a Khoe musical bow, and 'g!omah,' a type of braced musical bow used by the Ju|'hoansi Bushmen. Gregory (2018) views Ghoema as symbolizing the blending of various cultures, especially those of African and Eastern slaves. He goes on further to say that this unique ghoema rhythmic pattern represents people coming together and trying to live in harmony. Although its origins are diverse, today's producers and listeners are mostly connected through ethnic and family ties. The music revealed how people coped with daily challenges and exploitation (Gregory 2018). The Kaapse Klopse illustrates how music and performance play a crucial role in the cultural expression and communal identity of Coloured communities in Cape Town (Gregory 2018).

2.3 Stakeholders in the South African HealthCare system:

During apartheid in South Africa, a person's race and socioeconomic status were determining factors in whether one could access healthcare (Mhlanga & Garidzirai 2020). Although the country has been a democracy for over thirty years, inequality remains a significant issue, which also affects the healthcare system. Today, people's ability to access quality medical services is determined mainly by their financial status rather than their actual need for care (Mhlanga & Garidzirai 2020).

Most South Africans rely on public healthcare services. In 2019, data from Statistics South Africa indicated that 71.5% of households utilized public healthcare, while 27.1% relied on private healthcare. A small percentage (0.7%) of people also sought treatment from traditional healers. In 2017, the Department of Health highlighted the disparity in spending between public and private healthcare in South Africa. It is essential to note who controls these resources and who has access to them. The private healthcare sector, which serves only 16% of the population, spends 4.4% of the Gross Domestic Product (GDP- which is the total value of goods and services a country produces) more than the public sector, even though it serves far fewer people. Meanwhile, the public sector, which is responsible for 84% of the population, receives slightly less funding, at 4.1% of GDP.

Guise, Chambers, Lyng, Haraldseid-Driftland, Schibevaag, Fagerdal, Dombestein, Ree & Wiig (2024) explain that stakeholders are people or groups who have a role in, are affected by, or have an interest in the work of an organization or system. This includes both those who influence decisions and those who are impacted by them. In the healthcare system, stakeholders encompass anyone involved in providing, receiving, funding, or regulating services (Guise et al. 2024).In understanding the mental health landscape of the Cape Flats, it is essential to identify the key stakeholders who shape the way services are delivered, received, and experienced. This will focus on five key stakeholder groups: the Public sector, Private sector, NGOs, Mental Health professionals, and service users.

Recognizing these stakeholders helps to understand the dynamics that govern mental health provision for the Coloured community of the Cape Flats. This section addresses the primary stakeholders in mental healthcare and how their roles impact service delivery, with a particular focus on the perspectives of mental health professionals.

In the South African context, mental health professionals working in the public sector, in particular, are central to the delivery of mental healthcare services. The importance of understanding their perspectives becomes clear when considering the resource constraints, cultural nuances, and systemic challenges they face in their work.

2.3.1 Public Sector (Government and Health Authorities)

The government funds the South African public healthcare system. Government institutions are responsible for the bulk of mental health service provision, especially in low-income and marginalized communities. Young (2016) explains that public healthcare faces more challenges than private healthcare. These issues began during the Apartheid era, a period when healthcare was unequally provided based on racial groups, leading to a broken healthcare system. Mhlanga & Garidzirai (2020: 2) go on to say that public health is known for "long wait times, rushed appointments, old facilities, and poor disease control and prevention practices." Morar et al. (2024) state that 80% of the South African population uses public healthcare, and 16% have access to private healthcare. Public sector services are heavily impacted by limited resources, leading to challenges such as long waiting times, staff shortages, and underfunding (Sorsdahl, Petersen, Myers, Zingela, Lund, & Van Der Westhuizen 2023). Mental health professionals working within these systems often contend with these barriers, which shape their practice and influence their views on the effectiveness of the services they provide. This is particularly important for understanding the pressures placed on mental health workers in the Cape Flats, where public health services are the primary source of care for the majority of residents.

2.3.2 Private Sector (Private Healthcare Providers)

The government does not fund private healthcare. South African citizens are required to purchase their own private insurance to access private healthcare (Young 2016). In contrast to the public sector, private providers tend to serve a more affluent population, resulting in disparities in the quality and accessibility of care. Sorsdahl et al. (2023) estimate that around 80% of psychiatrists in South Africa Work in private healthcare. Mental health professionals in the private sector may also face distinct challenges, including managing patient expectations, navigating the commercial pressures of private practice, and addressing mental health needs in more affluent communities (Sorsdahl et al. 2023). Although the private sector

plays a minor role in the Cape Flats, it is crucial to understand its influence, particularly in shaping the expectations and perceptions of mental health professionals (Young 2016).

Understanding these dynamics is important because the concentration of mental health professionals in the private sector impacts the availability and quality of mental health services for the broader population, particularly in less affluent areas. It also shapes how mental health services are perceived and accessed, potentially reinforcing inequalities in care and influencing future policy and professional practice.

2.3.3 Non-Governmental Organizations (NGOs)

Rifkin (2001) explains that NGOs play a crucial role in building trust within communities. NGOs are essential stakeholders in mental health in South Africa, especially in underserved areas. A Non-Governmental Organization (NGO) is a non-profit, voluntary group that operates independently of government influence to address social, environmental, or humanitarian issues. NGOs play a crucial role in advocacy, service delivery, and influencing policy on both local and international levels (Lewis 2014). These organizations provide essential psycho-social support, mental health awareness, and community-based interventions that are often not available through formal healthcare services (Robertson, Moosa, & Jeenah 2021). Mental health professionals working in the Cape Flats may collaborate with these organizations, benefiting from their community engagement and outreach efforts. Mental health professionals should be aware of local community efforts that support well-being in conjunction with formal healthcare services. This understanding helps them provide care that respects cultural values and addresses people's needs more fully.

2.3.3 Human Resources

Human resources, such as psychologists, psychiatrists, social workers, and counsellors, are the primary providers of mental health services. They play a central role in the healthcare system. Determining how care is provided. Research has shown that these professionals in South Africa often face significant challenges, including high caseloads, limited resources, and the pressure to deliver quality care despite systemic limitations (Van der Westhuizen & Swartz 2015). In the Cape Flats, where historical trauma and social stigma surrounding mental health are prevalent, mental health professionals must also navigate the cultural and socio-political context in which they work (Cooper 2019). Their perspectives on how mental

health is conceptualized, treated, and addressed in the Cape Flats are crucial for understanding the barriers and enablers of effective service delivery.

Shisana et al. (2024) also note a shortage of mental health professionals. In the National Mental Health Policy Framework and Strategic Plan 2023-2030, the list of mental health human resources does not include any Arts Therapists. This omission is significant for this research, as Drama Therapy—which is a recognized alternative form of therapy—remains unacknowledged on a governmental level despite its active presence and utilization within communities. This raises important questions about why art therapies are not formally recognized in official policy, even though these interventions can play a valuable role in supporting mental health services. Cape Flats. Given the high demand for mental health services and the barriers to accessing traditional forms of therapy, exploring the role of Drama Therapy as a complementary intervention is necessary.

2.3.4 Service Users (Individuals Accessing Mental Health Services)

While this study focuses on the perspectives of mental health professionals, it is essential to acknowledge the role of service users in shaping the mental health landscape. Service users include individuals who seek mental health care and their families or informal carers. In the Cape Flats, mental health service users often experience stigma, marginalization, and a lack of trust in formal health systems, which can impact their willingness to seek care (Kagee et al. 2014). Mental health professionals' interactions with service users are shaped by these factors, influencing how they approach treatment and the therapeutic relationship. Service users' experiences, particularly in marginalized communities, highlight the need for culturally relevant and accessible mental health services.

By examining these key stakeholders, this literature review offers a more comprehensive understanding of the mental health system in the Cape Flats. It emphasizes the interconnectedness of different groups involved in mental healthcare, with a particular focus on the perspectives of mental health professionals who play a central role in shaping service delivery. This understanding is crucial for addressing the challenges and improving the mental health services available to the Coloured community in the Cape Flats.

Chapter Three:

Methodology

3.1 Research Design

A narrative enquiry recognizes that people interpret and understand their lives through the stories accessible to them. We are constantly restructuring stories based on new events and understanding that stories are shaped by personal and community narratives over time (Bell 2002). Humans are storytellers, shaping their lives and communities through stories. (Connelly & Clandinin 1990). The study of narrative, therefore, is the study of the ways humans experience the world. Narrative enquiry is not just about storytelling; it is the systematic study of how humans experience the world and construct meaning through stories. It is just as accurate to say "enquiry into narrative" as it is to say "narrative enquiry." By this, one means that narrative is both something we study and a way of studying (Connelly & Clandinin 1990).

Thus, this study employed a qualitative narrative research approach to explore the experiences, beliefs, and perceptions of mental health practitioners working with individuals in the Cape Flats community. Narrative research is particularly well-suited to this study, as it enables an in-depth understanding of how practitioners construct meaning from their experiences within a complex socio-political and cultural context. By centering participants' lived experiences and personal stories, this narrative research hopes to provide a rich, contextualized understanding of mental health service provision in the Cape Flats.

Furthermore, narrative inquiry aligns with the chosen theoretical framework of Critical Race Theory (CRT), as both emphasize the significance of storytelling in understanding lived experiences. CRT recognizes that personal and collective narratives provide valuable insights into how individuals navigate social structures and systemic influences (Bell 2002). Similarly, narrative enquiry values stories as a way of making sense of the world, acknowledging that experiences are shaped by historical, cultural, and institutional contexts (Connelly & Clandinin 1990). By using storytelling as both a method and a subject of study, this research contributes to a deeper understanding of how mental health practitioners,

working in the Cape Flats community, construct meaning from their work and engage with the complexities of service provision in a diverse and dynamic community.

3.2 Research Setting and Context

Before the 1950s, the Cape Flats was once nothing but a vast, empty expanse of sand, swept by the relentless winds. However, due to the enforcement of the Group Areas Act (1950) and Population Registration Act (1950), the barren land soon became a dumping ground for families removed from District Six and other communities (Oppelt 2024). Tight-knit communities were torn apart, disrupting the rhythm of daily life. (Pinnock 2016:12). In District Six, there had been a sense of belonging, a rhythm to community life. But in the Cape Flats, families found themselves in a space filled with fear, isolation, and uncertainty.

The Cape Flats region of South Africa has a history of marginalization, faces social and economic difficulties, and has limited access to mental health resources (Grobbelaar 2010; Trotter 2019; Van der Westhuizen & Gawulayo 2021). The area has a complex history shaped by apartheid-era forced removals, systemic poverty, gang-related violence, and substance abuse issues (Watt, Meade, Kimani, MacFarlane, Choi, Skinner, Pieterse, Kalichman & Sikkema 2014). All these factors point to the need for more mental health support. Thus, it is essential to first understand how practitioners, already working in the space, navigate their work within the environment. This study aims to capture the practitioners' insights into the accessibility, effectiveness, and cultural responsiveness of mental health interventions within the Cape Flats community.

3.3 Participant Selection

Having participants was crucial for this research, as their first-hand experiences and professional insights provided rich, context-specific data about mental health service provision in the Cape Flats. Their contributions enabled a deeper understanding of the challenges and realities faced in this community, which was essential to achieve the study's objectives.

3.3.1 Sampling Strategy

For this study, I used a purposeful sampling method. Purposeful sampling is a method in qualitative research that selects individuals who can provide valuable information, maximizing the use of limited resources (Patton, 2002; Creswell, 2018). This method focuses on selecting individuals or groups who have significant knowledge or experience related to the topic being studied (Cresswell & Plano Clark, 2011). Bernard (2002) and Spradley (1979) also emphasize that, beyond expertise, participants should be available, willing to engage, and able to share their experiences and perspectives clearly and thoughtfully.

In the case of this study, a purposeful sampling method was used to select participants who are mental health practitioners currently working with individuals from the Cape Flats community. This sampling technique ensures that participants have the relevant expertise and lived experience necessary to contribute to the research objectives. Participants were recruited through professional networks, word of mouth, and referrals from colleagues in the mental health field.

3.3.2 Inclusion Criteria

Participants were selected based on the following criteria:
- Must be a licensed or practicing mental health professional (e.g., psychologist, social worker, counsellor, Drama Therapist, arts therapist, music therapist, psychiatric nurse) or an educator (e.g., teacher) with relevant experience.
- Must have at least one year of experience working within the Cape Flats Coloured community.
- Must be willing to participate in a semi-structured interview and provide consent for audio recording and transcription.

3.3.3 Sample Size

The study aimed to recruit four mental health practitioners, ensuring a manageable yet diverse range of perspectives. Given the narrative approach, this sample size allows for in-depth exploration of personal experiences rather than generalizable findings. My participants were all classified as Coloured under South African racial classification, with ages ranging from 26 to 55, and included both male and female participants.

3.4 Data Collection Methods

3.4.1 Semi-Structured Interviews

Data was collected using semi-structured interviews. Dunn (2005) describes interviews as verbal exchanges in which an interviewer seeks to gather information from another person. There are three main types of interviews: structured, unstructured, and semi-structured. My study used a semi-structured approach. In this type of interview, the interviewer prepares a set of predetermined questions, but the conversation remains flexible, allowing participants to discuss topics they find meaningful (Longhurst 2003). The interview guide included open-ended questions designed to elicit rich narratives about participants' experiences, challenges, and reflections on mental health service provision within the Cape Flats.

Questions Included:

1. Can you tell me about your professional background and the work you do in mental health?
2. In what capacity (e.g., direct services, indirect services, individual, group, community-based) have you worked with Coloured communities or individuals in South Africa?
3. What are some common mental health challenges you encounter/see in your work with this community?
4. What cultural traditions, symbols, or practices do you connect or associate with Coloured communities?
5. What are some strengths you observe within Coloured communities that help support their mental well-being? (actions or practices that assist in maintaining or improving someone's mental health.)
6. What do you think are the key barriers to accessing mental health services in Coloured communities?
7. What challenges do mental health workers face when working with individuals or communities in Coloured areas?
8. Could you share how you came to work with Coloured communities or individuals? Was it through them seeking you out, your being placed in that context, or did you

actively choose to work with this group due to personal interest or professional inclination?

9. Do you find that Coloured individuals tend to seek help from formal mental health professionals, or do they turn to alternative spaces of support?
10. How do people in Coloured communities typically respond to mental health professionals? Are they likely to challenge or defer to authority?
11. How do language and communication styles impact therapeutic engagement in this context?
12. In your experience, how important is storytelling, role-play, or embodied expression in the therapeutic process for Coloured individuals?
13. How familiar are you with Drama Therapy (DT)?
14. Have you ever incorporated any creative or dramatic techniques in your work?
15. Do you see potential for Drama Therapy in primary, secondary, or tertiary healthcare settings? What factors would make it feasible or challenging?
16. Do you think there is a need for more culturally specific interventions? Why or why not?
17. If Drama Therapy were to be implemented in your setting, what support or resources (e.g., training, institutional support, policy frameworks) would be necessary to make it successful?

An online interview is a research method that takes place through computer-mediated communication, also known as CMC (Salmons 2014). The interview was synchronous as it was conducted in real time. I used Google Meet as my online platform which allowed myself and the participants to converse in real time. The reason for choosing online interviews was to carry out interviews from various geographical locations. This was mainly due to the fact that I was located in Johannesburg and most of my research participants reside in Cape Town.

Each online session lasted between 45 and 60 minutes and was recorded using an audio recorder, as well as being transcribed due to the use of Google Meet as my online platform. This was all done with prior informed consent obtained from all participants.

3.4.2 Transcription and Data Management

All recorded interviews were transcribed live verbatim by Google. As a researcher, I also listened back to the audio recording while reading the Google transcription to ensure accuracy. Transcriptions were securely stored on a password-protected device, and participants were assigned pseudonyms to maintain confidentiality and anonymity.

3.5 Method of Analysis

Thematic analysis is a method used to identify and organize patterns or themes within data, helping researchers make sense of key ideas that emerge (Roman 2019). This approach allows for a detailed examination of the data, ensuring that important themes are recognized and explored. Following Braun and Clarke's (2006) six-phase framework, the data is analyzed systematically, acknowledging that it is co-constructed. While some scholars argue that there are no fixed steps for thematic analysis, Braun and Clarke (2006), along with Saldana (2009), provide guidelines for coding and identifying themes to structure the analysis effectively.

The first step, according to Braun and Clarke's (2006) six-phase framework, involves getting to know one's data thoroughly. I did this by listening to the audio recordings and reading the transcriptions multiple times. As I reviewed the data, I actively engaged with it by taking notes, making annotations, and adding comments. This process helped me identify key ideas and concepts relevant to my research questions.

In Braun and Clarke's (2006) second step, I created initial codes to highlight important parts of my data. This helped me break down the information into smaller, more manageable pieces. To do this, I carefully read through my data and coded each section before proceeding to the next. I included as many patterns or ideas as possible, even if they didn't directly relate to my research questions.

The third step involved looking for themes by grouping similar codes. As I did this, I began to notice common ideas and key points in my research. I wrote these down and gathered related data under each theme so I could analyse them later.

The fourth step is centred around reviewing themes. Similar topics are grouped into broader categories, and the list is then checked for any repetition. This helped me create a clear

structure for the analysis. During this stage, I noticed that some themes lacked sufficient information to stand on their own. I also combined some themes to form a stronger central theme.

In the fifth phase, I identified and named themes by looking at what parts of my data they represented. This helped me understand my main themes, how they connect, and the stories they tell. Some themes were moved to different sections, some were combined, and others were simplified into examples based on their importance and the space available in this study.

Finally, the report is created, where the data is analysed. Relevant extracts are included in the discussion, along with references to existing literature, resulting in an academically informed analysis.

3.6 Ethical Considerations

Participants were fully informed about the nature, purpose, and procedures of the study before their participation. A consent form was sent to participants, whereby written informed consent was obtained from all participants, ensuring they understood their rights, including the right to withdraw from the study at any time without any repercussions. Participation in the study was entirely voluntary, and participants were informed that there would be no monetary compensation. Participants' confidentiality was rigorously upheld throughout the study; however, as I conducted the interviews personally, their identities were known to me. I have, however, ensured that personal identifiers were removed and pseudonyms used to ensure that individual responses cannot be traced back to any participant. Data was stored securely in a password-protected computer, and access was limited to me, the primary researcher.

3.7 Chapter Summary

This chapter has outlined the research design, participant selection, data collection methods, data analysis process, and ethical considerations for this study. By employing a narrative research approach and thematic analysis, this study aims to provide a rich, contextualized understanding of the experiences of mental health practitioners in the Cape Flats. The next chapter will present the findings and discussion of key themes emerging from the data.

Chapter Four:

Results and Discussion

Introduction:

Coles (1989) questioned how one fully grasps the complexity of certain life experiences. How can one put into words the mix of deep emotions one feels? Coles (1989) explains that the answer isn't found in theories or systems of ideas; instead, it's found in a story. Frank (2002) goes on further to say that people tell stories, not narratives. A narrative, as defined by Lawler (2002), is a story that includes change over time, actions, and characters, all connected within a plot. It helps people link the past and present, as well as themselves and others.

Before delving into their words, it is important to introduce the individuals who bring these stories to life. It is essential for me to acknowledge them not just as professionals, but as individuals whose experiences and insights shape the broader narrative of this research. In storytelling, characters play a crucial role in carrying the themes and messages of a narrative. Thus, the voices of these mental health professionals bring to life the intricacy, questions, and dedication required to support the Coloured community. Each participant's journey offers a unique perspective on mental health work, revealing the intersections of personal commitment, systemic challenges, and the ever-changing landscape of care. Their introductions provide a glimpse into their professional backgrounds, grounding their stories in the lived realities of their work. The first question I posed to them was about their professional background and the work they do in the field of mental health.

Daniel Fortuin's response was:

So my background is as a clinical psychologist. I've trained both as a research psychologist and a clinical psychologist. So I've completed a master's in research psychology that was structured, but I never registered as a research psychologist, and then subsequently I trained as a clinical psychologist, and I've done a range of things. So I've worked in community-based health. I've worked in private practice. I've worked in tertiary hospitals, psychiatric hospitals. I've worked in academic settings both as a director and therapist in student counselling, and that's at more than one university, and I've also worked as an academic, as a lecturer. Then I've also worked in student support services. I've been very busy. So a very wide range of work experiences as a clinician. Yeah.

Sarah Adams responded with:

I've been a social worker for about 30-odd years. So, I have an Honours degree in Social Work from the University of Cape Town, and I've worked for most of those 30 years. I've worked mostly in the field of children, working with children and families. So I have, over the years, worked for child protection organisations, doing statutory work. I worked for Childline and Safeline, doing assessments and counselling of childhood trauma, including child sexual abuse. Mostly, I've worked in adoptions. I'm back in adoption now. I've worked in medical for a short time, doing counselling for patients who were diagnosed with cancer. So I've worked in that field and then also in Hospice with end-of- life care. So, yeah, but most of it has been with children and families. Oh, and in the last couple of years, I have the last 10 years or so, I'm in a supervisory position. So, I supervise social workers. So I don't do direct practice. So I'm involved with supervision and training of social workers within the child protection field, and currently I'm a supervisor at an adoption organization.

Eddie David's response was:

So I currently work for a neurodivergent school, which consists of both a high school and a primary school. We work with learners who have autism. ADHD, learning barriers, such as dyslexia. So all of those types of learning barriers that learners have, those are the learners you work with. I am the head of sports, so I manage the sport for the school, but I also do the physical education and I'm also part of the support-based team in which I work closely with a social worker.

The experiences shared by the participants in this study showcase the diversity of professional backgrounds and the depth of expertise in working with various communities. From clinical psychology and social work to neurodivergent support in educational settings,

each participant brings a unique perspective on the challenges and opportunities faced in the mental health and therapeutic fields. These insights will serve as a foundation for exploring the four key themes that emerged during the interviews: Cultural Identity as a Bridge or Barrier, Understanding Community Pressures and Triumphs, The Roadblocks Faced by Mental Health Practitioners, and Drama Therapy in Action: Principles at Work. These themes offer critical lenses through which we can understand the intersection of professional practice, cultural identity, and therapeutic modalities in supporting individuals and communities. As we delve into these themes, we will further explore how practitioners navigate cultural complexities, overcome challenges, and integrate Drama Therapy principles into their work.

Cultural Identity: A Bridge or a Barrier?

The previous chapter emphasized that understanding the identity of Coloured communities in South Africa involves exploring their history, the personal experiences of community members, and the current social and political challenges they face (Adhikari 2004). Adhikari (2006) notes that Coloured identity is inherently ambiguous, with no single, clear-cut definition. From a social constructionist perspective, this ambiguity is not a limitation but a core aspect of how identity is created and experienced. This raises an important question for mental health practitioners: In the absence of a definitive understanding, how should they approach and engage with Coloured identity and the Coloured community as a whole?

It is important to remember that when people enter into an environment, they do not enter as blank canvases, waiting to be painted. Instead, they are already works of art, crafted by their own thoughts, experiences, and histories, stepping into a new gallery where their identities interact with the surrounding space. Coseo (1997) writes an article that shows us how Drama Therapists are able to uncover and face their own biases. This made it essential for me to first understand how mental health professionals perceive and associate with the Coloured community. What are the cultural traditions, symbols, or practices that one connects the Coloured communities to?

Eddie Davids:

Okay, the first thing that pops up is music, jazz, R&B, cleaning in the house on the weekend with the music as loud as ever at five different houses in the same street. People walking around the community, greeting one another, having a lot of mutual respect amongst themselves and on a more negative basis, violence, drug use-yeah, violence and stereotypes.

Daniel Fortuin:

So at an academic level I'm going to say, Coloured is not a homogeneous group, but given all the variations, there are essences, and I think those essences is maybe what you're asking about. So for me, there's a couple. The one thing is the oral tradition. This is not in Coloured communities. We don't write our history, we tell our history. We engage in storytelling. Knowledge is transferred through recounting of events.

Sharma (2016: 269) states that, " in an oral culture, words are spoken and once they have been said, the only record of them is in the memory of the speaker and any audience." McDrury & Alterio (2003:31) describe storytelling as a uniquely human experience that allows us to communicate, through language, aspects of ourselves, others, and the worlds, both real and imagined, that we inhabit. Language was a common topic that I came across with participants. Daniel Fortuin stated :

So, language is definitely different. There is a clear subculture in terms of language. There are words that mean certain things, it wouldn't mean the same thing anywhere else or it wouldn't even be a word anywhere else. But there are these 'dala what you must' for example, is a more recent thing. Which really means people just say, "dala jou ding" but what does it mean? It means 'do what you need to'. So there is a language and that provides an identity. I think the difficulty is that when health practitioners come in, even if they are from those communities, they don't then speak in that voice. They speak in the professional voice, they hold a professional identity, which then, in a sense, creates distance between them and the language that is an artifact of this sculptural subgroup."

Sarah Adams explain that:

You know, you talk, you speak Cape Flats, and it really depends. That's why, you know, we found that social workers who come from outside of the Cape, you know, and who basically, who don't even know the slang or two, you know, it's actually, it does impact.

What does it mean to speak Cape Flats? Some call it Kaaps while others call it Afrikaaps. They can be used interchangeably. Holtzman (2019:226) states Afrikaaps is, “language associated with the so-called Coloured people of Cape Town. Kaaps is both the root and fruit of standardised Afrikaans and was for a long time considered to be a bastardised pidgin dialect.”. It is described as a creole language, a language developed as a practical way for slaves to communicate. However, unlike other creole languages, such as Seychellois Creole, Kaaps has no official status in South Africa and is not used in formal settings (Eriksen & Oppelt 2025). Kaaps blends languages and has unique words and speech patterns. It also has a distinct way of being spoken, with specific tones and accents tied to race and social identity (Holtzman 2019).

Kaaps does, however, have a stigma attached to it. Carolissen (2016: 16) says that Kaaps has been referred to as kombuistaal *(kitchen language),* verbasterde taal *(bastardised language)* and gamtaal *(the language of Ham),* and as the language of the low social classes. However, there is an uprising as more people are rejecting the idea that Afrikaaps is an inferior language. An example of this is the 2009 theatre production and 2010 documentary Afrikaaps, directed by Dylan Valley, which gained national and international attention. The documentary challenges Afrikaaps’ association with colonial oppression and highlights Kaaps as belonging to the people who speak it (Valley 2010).

“Afrikaaps as a language in its own right and the identities of the people who speak it” (Holtzman 2019:3). Kaaps is more than just words; it carries cultural history, personal expression, and social belonging. Kaaps is more than just a dialect; it is a living language that reflects the complexities of identity, community, and history. Because the way people speak is deeply connected to their identity, communication in this context assumes a unique form.

When talking about the point of communication, Daniel Fortuin mentioned humour as an “essence” for describing the Coloured communities.

> *The other thing that is really important is the use of humour, and so the use of humour is quite a defining feature. There's a way of finding meaning in your subjective experience and finding meaning in your struggles. and where you find yourself, your situatedness by using humour. It's fast. it can get really black and dark. And it's quick-witted. But it's powerful. This is how you connect with people. You tell a joke.*

Humour, especially in the context of historically oppressed communities, operates on multiple levels. Irony, for instance, may seem playful on the surface, but beneath the mockery lies truth. As Jankélévitch (1964) suggests, humour requires a layered understanding. The first step in understanding humour is to recognize how serious situations can be exaggerated or turned into a comedy. Secondly, it is essential to realize that beneath the humour, truths are being expressed. Humour allows us to grasp the weight of reality, showing us the profound and often challenging experiences that lie beneath the laughter.

Humour is like a double-edged sword. It is both a source of laughter and a reflection of the harsh realities lived. Jankélévitch (1964) highlights that humour is not just about amusement, but it is also moulded by lived experiences, especially for those facing social and economic struggles. In the context of the Coloured community, humour becomes a tool for expressing truth in a way that is both accessible and communal.

Psychoanalyst Daniel Sibony (2010: 66-67) notes that laughter is a way of saying, “Laughing amounts to saying I am not alone, I am manifold”. Emielu (2020) then suggests humour enables people to build stronger connections with one another and thus creates a sense of belonging within a group. At the same time, it challenges and pushes back against the labels or identities that society tries to force on them. In communities where oppression is a daily reality, humour allows people to reconstruct their experiences, not by simply ignoring suffering, but by reclaiming agency over their narratives. Humour creates a shared understanding of both the joys and injustices of life. Laughter is more than an escape; it is a means of survival. Humour becomes a powerful form of communication, enabling both resistance and resilience.

But how do we, as humans, communicate with one another? Tiwari & Tiwari (2012) explain that our voices play a key role in the way we communicate. Our voices are how we express ourselves and connect with the world around us. However, verbal communication is not the only way in which we can communicate with one another. Gregersen (2007) states that nonverbal behaviour is an important part in how we communicate. She goes on to say that people use body language, facial expressions, tone of voice, timing, touch, personal space, appearance, and surroundings to communicate meaning. Eddie Davids said in our interview:

> *I think it's the ability to understand that, firstly, not all body language is meant to be disrespectful. Sometimes the body language, the way other people stand, the way they walk, the way they move their arms, it's just what they used to doing and what they're used to seeing on a day-to-day basis, that's the first thing.*

What Eddie Davids highlights here is that body language is not universally meaningful in the same way for everyone. What might appear disrespectful in one cultural or personal context might simply be habitual or natural for another person. It is important to be aware of body language; however, one must also resist the urge to assume its meaning without a deeper understanding. One interpretation might not necessarily be correct. Different people express themselves in different ways based on their lived experiences, cultural backgrounds, and personal habits. When observing body language, one must be careful but also see with an open mind. Meaning is not fixed, and assumptions can lead to misinterpretation.

Communication is vital for mental health professionals and their clients. Sarah Adams highlights the importance of communication:

> *Because I found over the years that even the most resistant client, the way you communicate, even for the parent where you have to make an alternative care plan for their children, if you are able to communicate your reasons and you are able to create rapport, you'll later find your whole service intervention from there becomes smooth because the client understands you were on their level. They will go with you, and they will support your plan because there's an understanding.*

Language, body language, and humour are more than just tools of communication; they are the foundations of how individuals express identity, navigate relationships, and make sense of the world. In communities where Afrikaaps is spoken, language carries historical and cultural weight, shaping both belonging and exclusion. Similarly, body language and humour serve as unspoken yet powerful forms of connection, resistance, and emotional processing. For mental health practitioners working in these spaces, understanding these dynamics is essential for building trust, fostering engagement, and ensuring responsive care.

The challenge is then not only about linguistic fluency but about cultural fluency. Practitioners must ask themselves, How is my own identity perceived in this space? How do

my language choices, gestures, and humour influence the therapeutic relationship? As Daniel Fortuin highlights:

> *I think that it is the responsibility of every provider to understand his or her audience and to ensure that those interventions are appropriate. So, for example, if I work with people who are traumatized, I'm not going to tell them to close their eyes because I understand that. But in the same way, if I'm working with a group of women from the church who aren't highly educated in the kind of traditional sense, I need to be able to understand that I must access their language. I must understand their references, which are within their faith, and be able to work with that.*

For mental health practitioners in these communities, it is clear that cultural identity is not just a background factor—it plays an active role in the therapeutic process. To truly see and be seen within these spaces, practitioners move beyond textbook approaches and embrace the lived realities of those they serve, recognizing that language, movement, and humour are not just expressions but lifelines to healing.

Understanding Community Pressures

Understanding the challenges a community faces is essential for any mental health professional, particularly in a historically marginalized area like the Cape Flats. The realities of economic hardship, systemic violence, and cultural resilience shape the lived experiences of those who call this community home. Mental health professionals do not exist outside of these contexts; instead, they work within them, thus inevitably influenced by the same social, historical, and emotional environment that their clients face. Respondents agreed that it is essential for mental health practitioners to engage with and acknowledge the community's struggles while also recognizing the strengths within these spaces. This section examines the complex challenges and successes of the Cape Flats, highlighting why an in-depth understanding of place is not only beneficial but also necessary for ethical and effective mental health practice.

Sarah Adams says:

> *What comes to mind for me when I think of the Cape Flats? I think of particularly lower socioeconomic communities. I think of high levels of unemployment. I think of low levels of education. So people who do not necessarily have a tertiary education, people who do not*

necessarily complete their high school careers. It's your more working-class communities, but also drug use, drug and alcohol use and abuse, which results in various socioeconomic challenges. You look at the lack of supervision of children. It doesn't mean that the whole community experiences it. Very interesting about working in the community is that there's a sense that not everybody is going to be down and out. You know, there's a sense of even though we all come from this community. Some of us make it, you know, and some of us don't. And that sense of resilience. And I've always been very interested to know what makes the difference? Because you're all exposed to the same kind of socioeconomic challenges. And yet it's not everybody who doesn't succeed in life.

Sarah Adams highlights key socioeconomic challenges faced by the Cape Flats, including high unemployment, low levels of education, substance abuse, and a lack of child supervision. Sarah Adams also touches on the complexity of the community, acknowledging both their struggle and resilience. She speaks to the fact that some individuals manage to succeed despite being exposed to the same adversities. This tension between hardship and perseverance is central to understanding life in the Cape Flats, yet beyond the well-documented issues of poverty, gangsterism, and Coloured identity, other significant but less researched challenges shape the lived experiences of residents (MacMaster 2010; Standing 2006; Van der Westhuizen & Gawulayo 2021).

One of the challenges that the community faces is described by Daniel Fortuin:

There's a lack of understanding of those diseases of lifestyle; they are thought to be genetic when they're not. They're actually just how people have learned to live, and that's cultural. and there isn't an understanding of how the psychological impact affects a person.. So people don't understand that when they are highly stressed, they get diabetes. They don't understand that when they're highly stressed the hypertension will be unregulated. One thing that I think has really been overlooked from a mental health perspective is that we kind of focus on trauma and we focus on schizophrenia and the substance stuff, but we overlook these diseases of lifestyle.

Sharma and Majumdar (2009) explain that lifestyle diseases are health problems caused by daily habits and an unhealthy relationship with one's environment. They usually develop slowly over many years, and once they appear, they are difficult to cure. These diseases are mainly linked to poor eating habits, lack of exercise, bad posture, and disrupted sleep patterns. What Daniel is suggesting is that there is a gap in mental health awareness within this community. There is a need for discussion with the community about how chronic stress

and lifestyle contribute to long-term health outcomes. Individuals may not recognize that their emotional distress, social pressures, and cultural norms around food, work, and rest are shaping their health outcomes. There is a focus on trauma, schizophrenia, and substance use, yet what Daniel calls for is a shift. A shift from a reactive approach, where one is treating illnesses once they manifest, to a preventative model that acknowledges the interconnectedness of mental and physical health.

The second challenge that this community faces has to do with illiteracy. Daniel Fortuin says:

> *Another thing that is there and it's always been fascinating for me is that it continues to be there, despite the advancement in illiteracy at different levels. So in some communities, people literally can't read. At other levels, they may be literate in terms of reading, but they will be quite illiterate in terms of health and medical knowledge, legal processes so there is a way in which there is a disenfranchisement that is systematically taking place in those communities where people don't challenge, they kind of make do.*

Daniel further explained how a lack of medical knowledge can seriously affect people's daily lives by using the example of *Timjan. Timjan* is a South African herbal tonic made from pure Aloe Ferox juice and fermented grape juice. Rich in vitamins, minerals, amino acids, and natural anti-inflammatory agents, it supports overall health and has no known side effects. However, there is no documented scientific proof to substantiate the benefits of *Timjan*. He provides a real-life example of how some individuals in these communities rely on traditional remedies, such as *Timjan*, believing it to be an effective cure for various illnesses. The belief in its healing properties is passed down orally from one person to another, rather than through careful research or medical advice. However, many people do not take the time to read the label, which clearly states that the product contains 17% alcohol. Because of this, they may think they are experiencing relief from their symptoms when, in reality, they are simply feeling the effects of alcohol intoxication. Daniel emphasized that this lack of awareness can be dangerous and that, in some cases, the misuse of these substances can be even more problematic than the use of illegal drugs, as people unknowingly consume them without understanding their true effects.

Physical space is also a challenge in the Cape Flats Community. One must remember that the Cape Flats were built with only a few entry and exit points, making it easier for authorities to

monitor and control the people living there during Apartheid. (Standing 2006). The thing to note is that the physical space has not changed since the displacement of many Coloured individuals. The Cape Flat was built to confine people, and it still does that today. Sarah Adams speaks to the overcrowding and that it is an issue in the community. She explained that in some areas, multiple families live on a single plot of land, sometimes with up to ten families sharing a space. In extreme cases, one household might consist of a single bedroom shared by parents and children. This lack of physical space raises important questions about child development—how do children grow and develop when they have no personal space? What impact does this have on their well-being?

For mental health professionals working in these communities, it is crucial to acknowledge the impact of overcrowding on emotional and psychological health. Limited space can contribute to stress, anxiety, and a lack of privacy, all of which affect overall well-being. Research supports this concern, as studies have shown that physical environments play a key role in mental health. Evans (2006) found that overcrowding can lead to increased psychological distress, especially in children, by reducing their ability to regulate emotions and find personal space. Busiol (2016) emphasized that a lack of space can heighten family conflict and negatively impact mental well-being.

Recognizing these challenges allows mental health professionals to approach therapy with greater awareness, considering how space limitations shape family dynamics and personal identity. Acknowledging the reality of overcrowding, professionals can help individuals find coping strategies, build resilience, and foster a sense of personal space, even within physically constrained environments.

The challenges faced by the community, poverty, limited medical literacy, and constrained physical space, are not isolated issues but rather symptoms of broader systemic inequities. These conditions shape individuals' access to healthcare, education, and opportunities for self-expression, reinforcing cycles of marginalization. When working within such communities, it is essential to recognize that these structural barriers are not simply personal or cultural deficits but the result of historical and socio-political conditions. Interventions without an awareness of these factors risk reinforcing the very exclusions we seek to address.

The Roadblocks Faced by Mental Health Practitioners

While much attention is given to the challenges that the communities face in their daily lives, it is equally important to acknowledge the challenges experienced by professionals working within the environment. Mental health practitioners, whether they are psychologists, social workers, or teachers, all operate within systems that may sometimes challenge their ability to provide effective care. These roadblocks shape both their professional experiences and the quality of support they can offer. Understanding these challenges is crucial in addressing the gaps within the mental health profession and ensuring sustainable, impactful care.

Daniel Fortuin says that:

> *I think the other really important thing is a sense of community, there's a sense of knowing your neighbour, being interested in your neighbour, sharing the burdens of your neighbour. and that survival is only possible through collective effort. There is a shared celebration of achievements, there are shared celebrations of accomplishments, and there is shared sorrow.*

He goes on further to say that there are structural challenges that exist within the psychology discipline, recording its application in this context, particularly regarding the distinction between direct and indirect services. Practitioners are trained to recognize indirect services such as advocacy, psychoeducation, and workshops, but these are often side-lined. The expectation frequently falls on people of colour to engage in community-based work, while many clinicians do not integrate these approaches into their standard practice. Additionally, he suggests that psychology remains heavily focused on individual therapy conducted behind closed doors, limiting broader, community-centred interventions.

This emphasis on individualized therapeutic work presents a significant challenge when applied to communities where collective processes are central. In settings where communal healing, shared storytelling, and group support structures are fundamental, an individual-centred approach may not fully address the needs of the people being served.

The tension between individualism and communitarianism becomes evident in this context. Individualism focuses on the individual, their personal freedom, and independence. It values self-reliance and making choices based on personal needs (Triandis 1995). Communitarianism emphasizes the community and the importance of collective effort. It

values social responsibility and the well-being of the group over individual desires (Etzioni 1993). The two are different because individualism prioritizes the individual, while communitarianism prioritizes the community (Etzioni 1993; Triandis 1995).

Traditional psychological models, largely influenced by Western paradigms, prioritize self-exploration and one-on-one therapeutic relationships. However, many communities, particularly in collectivist cultures, function through shared responsibility, interdependence, and collective healing practices (Glass & Rud 2012). Focusing solely on individualized care neglects the social, historical, and cultural frameworks that shape people's experiences. A shift is required to recognize and integrate communal methodologies, ensuring that psychological services are both culturally relevant and accessible.

This left me, as the researcher, wondering what the healing network looks like in this community. Daniel Fortuin explains that community health clinics in these areas are readily accessible due to the high numbers of lifestyle-related diseases. The practitioners, who are usually nurses and medical doctors, often become aware of patients' psychological challenges. However, these issues are frequently overlooked or addressed with prescriptions. Rather than receiving treatment based on a clear diagnosis, patients are often prescribed medications such as benzodiazepines, which are intended to induce relaxation or aid sleep. As a result, many individuals in these communities rely on medications like amitriptyline, an older drug with side effects that provides only temporary relief from stress and anxiety. However, their underlying problems remain undiagnosed and untreated, which is a concerning issue, says Daniel Fortuin.

In my interview with Sarah Adams, she brings to light that historically, welfare services in this community functioned as a central hub where people would go for help for a wide range of issues, from securing pensions and school placements to receiving food parcels or applying for housing. This accessibility created a sense of familiarity and trust, as individuals knew they could turn to a single organization for support. However, Sarah explains that social work over the years has become more specialized, and services are now divided into distinct sectors, requiring people to navigate multiple institutions to address their different needs. This shift, while reflective of broader systemic changes, disrupted the community's established way of seeking help, making support feel more fragmented and less accessible.

Many struggled with the transition, feeling frustrated by the increased complexity of accessing services and the perceived reduction in available assistance.

Despite these facilities being used in this community. Daniel Fortuin states that the first point of call is the community. He uses the example of a practice in which individuals share medication, consuming one another's prescribed medication without knowing the medication's name or dosage. From a mental health professional's perspective, this highlights the critical need for psychoeducation, particularly in these communities where misinformation and risky health practices are common. Without proper knowledge, individuals may unknowingly worsen their conditions or delay seeking appropriate treatment.

Through all interviews, it became apparent that issues often escalate to community structures such as schools and churches, which are recognized as authoritative spaces. It is common for individuals to seek help from pastors or school principals rather than trained mental health professionals. Daniel Fortuin explains that:

> *There are people who are providing really essential services, and in those services, they perform psychological work. So, your uncle, who organizes everybody, and the teacher are doing psychological work. They're not psychologists. They're not counsellors or therapists necessarily, the auntie that everybody talks to for advice. They're doing psychological work.*

Eddie Davids explains :

> *So I often say that in my field of work, you are not only a teacher, you're also a counsellor, a therapist, a parent, everything that the learner needs. And often the learners tell you things, and you just have to be supportive here, and also refer them to the social worker.*

Both of these extracts highlight the reality that psychological work is not confined to formal mental health professionals but is woven into the everyday roles of community members. Teachers, family members, and informal leaders naturally take on counselling and therapeutic functions. It seems as if they often provide the first line of emotional and psychological support. This raises important questions about who holds responsibility for mental well-being in a community and the extent to which these individuals are equipped to manage the psychological burdens placed upon them. For mental health practitioners, recognizing these informal support systems is crucial to understanding what informs the design of interventions and where resources should be directed. It also underpins the importance of collaboration

between trained professionals and community figures to ensure that psychological work is sustainable and does not lead to burnout among those offering support without formal training.

For a mental health practitioner working in this community, these dynamics present both challenges and opportunities. The reliance on family, teachers, and religious leaders suggests that integrating psychoeducation within these trusted spaces could improve mental health literacy and early intervention. Additionally, understanding these help-seeking patterns allows professionals to collaborate with community leaders to bridge the gap between informal support and formal mental health services.

When I asked participants about their roles in the community, a common workplace emerged; they are or had been employed within the NGO sector. As stated previously, a Non-Governmental Organization (NGO) is a non-profit, voluntary group that operates independently of government influence. NGOs play a crucial role in advocacy, service delivery, and influencing policy on both local and international levels (Lewis 2014).

For mental health practitioners, this means that NGOs are likely to be key employers and facilitators of mental health services, especially in underserved communities. Practitioners working in NGOs often face challenges related to funding, resource limitations, and a strong emphasis on advocacy and community-based interventions. Additionally, the NGO sector's independence from government influence may provide opportunities for innovative approaches to mental health care. Still, it could also require practitioners to engage in advocacy to secure resources and policy support.

One thing that is important to note is what Sarah Adams said:

> *I've worked in organizations that were long-standing within these communities, so they weren't new organizations. They were there for like decade, social welfare officers that were in communities for 20 years, 30 years. So it's part and parcel of the makeup of the community, so I think it's really important to know that there was a trust relationship over time.*

This underscores the importance of consistency, commitment, and time in establishing meaningful connections and credibility within a community. We can recognize that trust is

not built overnight, but rather develops through sustained engagement and a demonstrated commitment to the community's well-being.

The roadblocks that mental health practitioners face are not dead ends but rather obstacles that shape the journey. Much like navigating the pothole-ridden roads of South Africa, practitioners learn to manoeuvre around challenges, sometimes experiencing setbacks but ultimately gaining insight for the road ahead. The issues discussed—community dynamics, the healing network that includes teachers and families, and the prevalence of NGOs as primary workplaces —are not barriers that prevent the work from happening; rather, they should be seen as what defines the environment in which mental health practitioners operate. Understanding these factors is essential, not as reasons for discouragement, but as realities that shape the practice, requiring adaptability, resilience, and an ongoing commitment to those in need of care.

Drama Therapy in Action: Principles at Work

According to Jones (2007), Drama Therapy is effective because of several core processes that underpin its practice. These processes are not merely techniques or methods but rather foundational elements that are inherently therapeutic in nature. In this section, I will focus on some of Phil Jones' core processes already being utilized within the community described by my participants.

Sarah Adam explains:

> *Role play is even part of social training. Role play has always been something that is kind of part of what we are. We are kind of encouraged to use it and engage with it because it helps develop empathy. To put yourself in the person's shoes, and so using role-play um, I would say it's a very important part of social training. So when you're working with your clients, we work on three methods in social work. You have case-work, which is your individual one-on-one. Then group work, which is working with groups, and then, of course, community development, which is working with larger communities, so especially within your group work and within your community development, the use of role playing and the use of storytelling is just quite common, and you know we actually make use of it quite a bit.*

In this extract, two core Drama Therapy processes are evident. The first is role play. Role-playing, also known as role-taking, involves individuals portraying themselves, an imaginary character, or someone from their life experiences through dramatic improvisation. In Drama Therapy, this process enables clients to express their feelings, concerns, or aspects of themselves through role-playing (Jones 2007). Through these techniques, clients can explore different perspectives, either by stepping into another person's shoes or examining their own life from a different viewpoint. This helps build empathy and develop better relationships with themselves and others. Additionally, using fictional elements provides a space for clients to explore and transform issues they may feel unable to address in their everyday lives (Jones 2007).

The second core process found in this extract is empathy. Empathy, as Brene Brown (2019) describes it, fuels connection. Clark (2010:95) states," Empathy offers a way for a mental health counsellor to grasp the feelings and meanings of a client and convey this understanding to the client". Empathy requires a connection and a deep level of understanding, which enables individuals to offer genuine support and care.

Jones (2007) explains that empathy involves emotional connection and understanding, which are crucial when engaging in dramatic activities. Developing an empathic response to roles, situations, or objects within a dramatic work can be essential to therapy. A lack of empathy may be a contributing factor for clients who struggle to form relationships or understand others. Encouraging empathy in Drama Therapy can help clients develop this skill, fostering better connections in their everyday lives (Jones 2007).

The development of empathy within a community transcends basic understanding; it serves as the foundation for genuine human connection and transformation. In communities where empathy thrives, members are not just passive observers of one another's struggles and triumphs, but active participants in each other's growth and development. When empathy is nurtured, individuals feel seen and valued—not despite, but because of their unique experiences and challenges. This recognition dismantles barriers of isolation or difference, making room for authentic relationships and collective healing.

Empathy in a therapeutic or creative community setting, such as Drama Therapy, opens avenues for deeper self-awareness and insight. When members empathize with each other's

roles, stories, or emotional states, they foster an environment of psychological safety—an essential ingredient for vulnerability and change. In doing so, empathy becomes a catalyst for personal and communal evolution, transforming individual healing into a shared journey. Ultimately, a community grounded in empathy is not just supportive, but transformative, empowering members to confront adversity, inspire growth, and co-create a culture of compassion and connection.

Sarah Adam further explains that in her field of social work:

> *So over the years, as when I was doing more direct practice and doing more kinds of work directly with children and adolescents, I think the role playing and the acting and the dancing work fantastically because, you know, children don't want to sit and talk. You know, that's not the medium. Children's medium of communication prior medium of communication is play.*

Play is another core process described by Jones (2007). In Drama Therapy, play refers to a process where both children and adults engage in a playful state that allows them to step away from reality and enter a more imaginative realm. It creates a space where clients can explore time, space, and everyday rules more flexibly and creatively. This type of playfulness doesn't have to be humorous; instead, it involves a shift in how individuals view events, consequences, and ideas, offering a new perspective (Jones 2007).

Another key process that frequently emerged was the recognition of the need for interventions to be group-based. Daniel Fortuin states:

> *People would work better in a group. People would be more susceptible to group-based interventions*

Jones (2007) explains that witnessing in Drama Therapy refers to observing others or oneself within a therapeutic setting. It involves both the opportunity for individuals to witness others' expressions and for their own experiences to be witnessed by the group or therapist (Jones 2007). Witnessing is seeing someone walking in their shoes. Some say you will never be able to walk into someone else's shoes, but it is essential to witness them walking in their shoes. This process can occur in various forms, such as brief moments where one person observes another’s improvisation, or more extended periods when the group or therapist serves as an audience to an individual's role-play or enactment (Jones 2007).

In group-based interventions, witnessing plays a crucial role in fostering connection and growth. The process of witnessing plays a vital role in fostering connection, empathy, and understanding among participants. Daniel Fortuin suggests that people often work better in a group because they are more susceptible to group-based interventions. This dynamic allows individuals to not only share their experiences but also to observe others navigating similar challenges. The act of witnessing in this context goes beyond mere observation; it involves a collective acknowledgment and validation of each person's experience.

Jones (2007) explains that witnessing offers an opportunity for individuals to see others express themselves authentically and to have their own experiences recognized by the group or therapist. Witnessing helps individuals feel seen and heard in a way that promotes healing and growth—in group-based interventions, witnessing fosters a shared space where individuals can experience both vulnerability and empowerment, ultimately enhancing the therapeutic process.

Lastly, one thing that came up with the use of the Arts in the Coloured community. Daniel Fortuin says:

> *I cannot think of a Coloured community that does not have a dance class whether that is a formal dance class or an informal dance class where the kids in the class get together and they're working out sequences, I'm always amazed at how, Michael Jackson had these special shoes made so you could do the lean and five minutes later the whole Cape Flats was doing this lean. These things happen. They're there. It's not being harnessed. I mean, for me it's just very simple. If you take any dance group and you say to them, "Let's break down what you've done. You've practiced until you get it right. That's discipline, that's perseverance, that's resilience. You choreographed, and you didn't let the worst answer do the most difficult route. So, you've actually worked on the strengths of individuals, which means that you've done an assessment, so that's not the words they use. They just do it. And I think that's what's needed. We need to be able to translate.*

The principles of Drama Therapy, such as role play, empathy, and play, are already deeply embedded in the practices used within the community. These techniques help individuals explore different perspectives, build empathy, and connect with others, mirroring the therapeutic methods of Drama Therapy. Group-based interventions, particularly the act of

witnessing, foster emotional healing and shared support. As Daniel Fortuin highlights, the prevalence of dance in the community serves as a powerful example of how arts-based practices promote discipline, resilience, and collaboration. The connection between dance and therapeutic elements, such as perseverance and teamwork, is evident, demonstrating how the community already engages in practices that align with the core principles of Drama Therapy. By harnessing these artistic practices, mental health professionals can more effectively connect with their clients. Drama Therapy, with its emphasis on play and creative expression, has much to offer in fostering emotional healing and community connection, ultimately deepening the therapeutic process within this context. By tapping into these existing artistic practices, Drama Therapy can further enhance emotional expression, cultural identity, and community connection.

One interesting takeaway from all the interviews was that everyone agreed there isn't necessarily a need for more culturally relevant interventions, but rather a need for more interventions overall. Daniel Fortuin states:

> *I think there's a need for an intervention period. I think that it is the responsibility of every provider to understand his or her audience and to ensure that those interventions are appropriate.*

Fortuin's perspective suggests that rather than focusing solely on cultural specificity, the priority should be expanding access to interventions in general while ensuring that providers are equipped to adapt their approaches to the communities they serve. This underscores the importance of increasing the number of professionals working in these spaces and fostering a deeper understanding of community needs. For my research, this finding emphasizes that the issue may not be a lack of culturally tailored Drama Therapy methods, but rather a systemic shortage of services and practitioners. This suggests that advocacy for more mental health professionals in Coloured communities, along with education on adaptable, responsive care, could be just as, if not more, impactful than developing new intervention models.

Chapter Five:

Conclusion

In this research, I set out to explore how mental health professionals working with Coloured communities in Cape Town's Cape Flats perceive the cultural, structural, and practical factors influencing mental health services, with a particular focus on the role of creative arts therapies, specifically Drama Therapy. The findings from the interviews revealed the complexities of mental health care within these communities, highlighting both the challenges and strengths present in the therapeutic environment.

This study has uncovered how mental health professionals must adapt their practices to navigate the cultural richness and socio-economic realities of Coloured communities. The research has identified key mental health challenges, understanding community pressures, and exploring the potential for creative arts therapies to support emotional healing.

The first theme, *"Cultural Identity as a Bridge or Barrier*," emphasized that cultural fluency, extending beyond linguistic competence, is crucial for effective therapy. Practitioners must be attuned to the unique language, humour, and body language that are intrinsic to the community's identity. This understanding is crucial for establishing a therapeutic relationship that is both authentic and effective. In the second theme, *Understanding Community Pressures and Triumphs*, I identified systemic barriers, such as poverty and limited medical knowledge, that continue to marginalize these communities. Recognizing these broader issues helps practitioners avoid seeing them as personal deficiencies and instead view them within their historical and socio-political context.

The third theme, *"The Roadblocks Faced by Mental Health Practitioners*," revealed that while practitioners face challenges such as community dynamics and limited resources, these are inherent to the environment in which they work and require flexibility and resilience. The final theme, *Drama Therapy in Action: Principles at Work*, illustrated how the principles of Drama Therapy, such as role play, empathy, and play, are already deeply embedded within the community's cultural practices as well as the disciplines being used. These practices align with the therapeutic methods of Drama Therapy and can be further harnessed to foster emotional healing and build stronger connections within the community.

In conclusion, my research has not only answered the primary research question but also highlighted the importance of cultural awareness, structural understanding, and the integration of creative arts therapies in mental health care. The study achieved its aims by shedding light on the complex interplay of factors that influence mental health services in the Cape Flats Coloured communities and exploring how Drama Therapy can be a valuable tool in addressing these challenges. Ultimately, this research contributes to the ongoing conversation about mental health interventions that honour the lived experiences of marginalized communities.

Limitations

One of the main limitations of this study was the challenge of assembling a diverse group of mental health professionals to participate in the research. Initially, the intention was to conduct a workshop involving various mental health professionals to gather a wide range of perspectives. However, due to time constraints and the willingness and availability among potential participants, this plan had to be adapted. As a result, the study shifted to one-on-one interviews, which, while still valuable, limited the scope of perspectives that could have been gathered in a group setting.

Another limitation was the small sample size of mental health professionals. Only three professionals from the Coloured community participated in the study. This limited sample size may not fully represent the diversity of experiences, beliefs, and practices within the broader community of mental health professionals working in Coloured communities in the Cape Flats.

Furthermore, one of the significant limitations of this research is the recognition that the Coloured community in South Africa is not a homogeneous group. The cultural, social, and economic differences across Coloured communities in different regions of the country mean that there is no "one size fits all" approach to mental health interventions. The findings from this study may therefore not be generalizable to all Coloured communities, as the needs and perspectives of individuals within these communities may differ depending on their geographic location and specific socio-cultural contexts. This limitation underscores the complexity of conducting research in diverse populations. It highlights the need for more localized studies to better understand the nuances of mental health and creative arts therapies within specific communities.

Significance

The significance of this study lies in its ability to address a critical gap in the current understanding and practice of mental health services within communities of colour. By focusing on the perceptions and experiences of Coloured professionals working in mental health and creative arts therapies, the study aims to provide valuable insights into how these communities engage with mental health care and the role of innovative interventions. Despite growing recognition of mental health challenges, there remains a lack of tailored, accessible interventions that meet the unique needs of these communities. Furthermore, this research highlights the potential for Drama Therapy to bridge the gap between conventional mental health care and the specific needs of Coloured communities. By examining how these therapies are perceived and applied, the study can contribute to the development of more inclusive and effective therapeutic practices that build upon the traditional approaches already established in this community. It is not only about broadening the scope of therapeutic practices but also about advocating for the integration of creative methodologies in addressing mental health challenges within South Africa's diverse communities. Through this study, we are now better equipped with more practices to enhance mental health care in these communities, offering valuable tools that can be used to address the challenges they face.

Reference List

Adhikari, M., 2004. 'Not black enough': changing expressions of Coloured identity in post-apartheid South Africa: feature: ten years of democracy. *South African Historical Journal*, *51*(1), pp.167-178.

Adhikari, M., 2006. Hope, fear, shame, frustration: Continuity and change in the expression of Coloured identity in white supremacist South Africa, 1910–1994. *Journal of Southern African Studies*, *32*(3), pp.467-487.

Adhikari, M., 2009. *Burdened by race: Coloured identities in Southern Africa*. UCT press.

Alterio, M. and McDrury, J., 2003. *Learning through storytelling in higher education: Using reflection and experience to improve learning*. Routledge. Approaches (3RD Edition). SAGE Publications, Inc.

Artz, S., Jackson, M.A., Rossiter, K.R., Nijdam-Jones, A., Géczy, I. and Porteous, S., 2014. A comprehensive review of the literature on the impact of exposure to intimate partner violence on children and youth.

Bell, J.S., 2002. Narrative inquiry: More than just telling stories. *TESOL Quarterly*, *36*(2), pp.207-213.

Bernard, HR. Research methods in anthropology: Qualitative and quantitative approaches. 3rd. Alta Mira Press; Walnut Creek, CA: 2002.

Booysen, D., Mahe-Poyo, P. and Grant, R., 2021. The experiences and perceptions of mental health service provision at a primary health centre in the Eastern Cape. *South African Journal of Psychiatry*, *27*, p.1641.

Booysen, D., Mahe-Poyo, P. and Grant, R., 2021. The experiences and perceptions of mental health service provision at a primary health centre in the Eastern Cape. *South African Journal of Psychiatry*, *27*, p.1641.

Braun, V. and V. Clarke. 2006. Using thematic analysis in psychology. Qualitative Research

Brown, B., 2019. *Empathy* [online] (Accessed 21 January 2025).

Burns, J.K., 2011. The mental health gap in South Africa: A human rights issue. *The Equal Rights Review*, *6*(99), pp.99-113.

Busiol, D., 2016. A review of research on the consequences of living in a high-density city. *International Journal of Child & Adolescent Health*, *9*(4).

Carolissen, J., 2016. *Afrikaans on the Cape Flats: Performing cultural linguistic identity in Afrikaaps* (Doctoral dissertation, Stellenbosch: Stellenbosch University).

Christopher, A.J., 2002. 'To define the indefinable': population classification and the census in South Africa. *Area*, *34*(4), pp.401-408.

Clacherty, G., 2014. The Suitcase Project: Working with unaccompanied child refugees in new ways. In *Healing and change in the city of gold: Case studies of coping and support in Johannesburg* (pp. 13-30). Cham: Springer International Publishing.

Clandinin D. J., & Huber, J. (2010). Narrative inquiry. In B. McGaw, E. Baker, & P. Peterson (Eds.), *International encyclopaedia of education* (pp. 436-441). New York: Elsevier.

Clark, A.J., 2010. Empathy and sympathy: Therapeutic distinctions in counselling. *Journal of Mental Health Counseling*, *32*(2), pp.95-101.

Cloete, E.J., 2020. *Drama therapy for school dropouts? An exploration of the potential role of Drama Therapy as a therapeutic intervention in working with a group of Grade 10 school dropouts in Katutura, Namibia* (Doctoral dissertation).

Coles, R., 1989. *The call of stories: Teaching and the moral imagination*. Houghton Mifflin Harcourt.

Connelly, F.M. and Clandinin, D.J., 1990. Stories of experience and narrative inquiry. Educational researcher, 19(5), pp.2-14.

Corry, W. and Terre Blanche, M., 2000. Where does the blood come from? True stories and real selves at the TRC hearings. *Psychology in Society*, *26*, pp.6-17.

Coseo, A., 1997. Developing cultural awareness for creative arts therapists. *The Arts in Psychotherapy*, *24*(2), pp.145-157.

Craig, A., Rochat, T., Naicker, S.N., Mapanga, W., Mtintsilana, A., Dlamini, S.N., Ware, L.J., Du Toit, J., Draper, C.E., Richter, L. and Norris, S.A., 2022. The prevalence of probable depression and probable anxiety, and associations with adverse childhood experiences and socio-demographics: A national survey in South Africa. *Frontiers in Public Health*, *10*, p.986531.

Crenshaw, K., Gotanda, N., Peller, G., and Thomas, K. eds., 1995. *Critical race theory: The key writings that formed the movement*. The New Press.

Cresswell, JW.; Plano Clark, VL. 2011. Designing and conducting mixed method research. 2nd. Sage; Thousand Oaks, CA

Creswell, J. W. (2018). Qualitative Inquiry & Research Design: Choosing Among Five

De Wet, A. and Pretorius, C., 2022. From darkness to light: Barriers and facilitators to mental health recovery in the South African context. *International Journal of Social Psychiatry*, *68*(1), pp.82-89.

Department of Health, South Africa (2023) *National Mental Health Policy Framework and Strategic Plan 2023–2030*. Pretoria: Department of Health. Available at: https://www.spotlightnsp.co.za/wp-content/uploads/2023/04/NMHP-FINAL-APPROVED-ON-30.04.2023.pdf (Accessed 19 January 2025).

Dhai, A., 2018. The Life Esidimeni tragedy: Moral pathology and an ethical crisis. *SAMJ: South African Medical Journal*, *108*(5), pp.382-385.

Du Preez, J., 2021. *An exploration of the use of Drama Therapy to discover ways of talking about racial identity with teachers in order to promote integration in our classrooms* (Doctoral dissertation) (Accessed 21 January 2025).

Emielu, A., 2020. Cape Town Harmonies: Memory, Humour and Resilience: by Armelle Gaulier and Denis-Constant Martin, Cape Town, African Minds, 2017, xxvii 337 pp.

Emunah, R. 1994. Sources. Acting for Real: Drama Therapy, process, techniques, and Performance. New York: Taylor & Francis Group

Eriksen, T.H. and Oppelt, R., 2025. Post-apartheid diversification through Afrikaaps: language, power and superdiversity in the Western Cape. *Ethnic and Racial Studies*, pp.1-16.

Etzioni, A. (1993) . *The Spirit of Community: Rights, Responsibilities and the Communitarian Agenda*. New York: Crown Publishers.

Evans, G.W., 2006. Child development and the physical environment. *Annu. Rev. Psychol.*, *57*(1), pp.423-451.

Frank, A.W., 2000. The standpoint of storyteller. *Qualitative health research*, *10*(3), pp.354-365.

Fransman, G., 2005. *Negotiating Coloured identity through encounters with performance* (Doctoral dissertation, University of the Western Cape). (Accessed 21 January 2025).

Gamieldien, F., Galvaan, R., Myers, B., and Sorsdahl, K., 2024. Mental health service users and their caregivers perspectives on personal recovery from severe mental health conditions in Cape Town, South Africa: A qualitative study. *Journal of Psychosocial Rehabilitation and Mental Health*, *11*(2), pp.201-219.

Gamieldien, F., Galvaan, R., Myers, B., and Sorsdahl, K., 2024. Mental health service users and their caregivers perspectives on personal recovery from severe mental health conditions in Cape Town, South Africa: A qualitative study. *Journal of Psychosocial Rehabilitation and Mental Health*, *11*(2), pp.201-219.

Glass, G.V. and Rud, A.G., 2012. The struggle between individualism and communitarianism: The pressure of population, prejudice, and the purse. *Review of Research in Education*, *36*(1), pp.95-112.

Gregersen, T.S., 2007. Language learning beyond words: Incorporating body language into classroom activities. *Reflections on English language teaching*, *6*(1), pp.51-64.

Grobbelaar, D., 2010. Psychosocial rehabilitation for people with mental illness in the South African context: an evaluation from a service-users perspective.

Guise, V., Chambers, M., Lyng, H.B., Haraldseid-Driftland, C., Schibevaag, L., Fagerdal, B., Dombestein, H., Ree, E., and Wiig, S., 2024. Identifying, categorising, and mapping actors involved in resilience in healthcare: a qualitative stakeholder analysis. *BMC Health Services Research*, *24*(1), p.230.

Harriman, N.W., Williams, D.R., Morgan, J.W., Sewpaul, R., Manyaapelo, T., Sifunda, S., Mabaso, M., Mbewu, A.D., and Reddy, S.P., 2021. Racial disparities in psychological distress in post-apartheid South Africa: results from the SANHANES-1 survey. *Social psychiatry and psychiatric epidemiology*, pp.1-15.

Heathcote, D. and Bolton, G., 1994. *Drama for Learning: Dorothy Heathcote's Mantle of the Expert Approach to Education. Dimensions of Drama Series*. Heinemann, 361 Hanover St., Portsmouth, NH 03801-3912.

Holtzman, G., 2019. Coming-out of the Coloured closet: An Afrikaaps renaissance in the arts. *Stilet: Tydskrif van die Afrikaanse Letterkundevereniging*, *31*(1), pp.226-230.

HPCSA. 2023. *Occupational Therapy, Medical Orthotics, Prosthetics & Arts Therapy*. Available:https://www.hpcsa.co.za/?contentId=0&menuSubId=49&actionName=Professional%20Boards (Accessed 7 February 2025).

Hutton, E., 2019. *Fighting Monsters Through the Vulnerable Hero: An Examination of Techniques of Role Play Within Drama Therapy for Children Who Have Experienced Trauma in South Africa* (Master's thesis, University of the Witwatersrand, Johannesburg (South Africa) in Psychology 3(2): 77–101.

Jackson, P.B., Williams, D.R., Stein, D.J., Herman, A., Williams, S.L., and Redmond, D.L., 2010. Race and psychological distress: The South African stress and health study. *Journal of Health and Social Behaviour*, *51*(4), pp.458-477.

Jankélévitch, Vladimir (1964) L'ironie. Paris: Flammarion

Jennings, S., Cattanach, A., Mitchell, S., Chesner, A., Meldrum, B., and Nfa, S.M., 2005. *The handbook of dramatherapy*. Routledge.

Jones, P., 2007. *Drama as therapy volume 1: Theory, practice and research*. Routledge.

Kaminer, D., Du Plessis, B., Hardy, A., & Benjamin, A. (2013). Exposure to violence across multiple sites among young South African adolescents. *Peace and Conflict: Journal of Peace Psychology*, 19(2), 112–124.

Khan, J.F., 2018. *" So, what are you?": analysing erasure, shame and (mis) appropriation of Coloured narratives in South Africa through social media* (Doctoral dissertation).

Kim, A.W., Nyengerai, T. and Mendenhall, E., 2020. Evaluating the mental health impacts of the COVID-19 pandemic in urban South Africa: perceived risk of COVID-19 infection and childhood trauma predict adult depressive symptoms. *Medrxiv: The Preprint Server for Health Sciences*, 1.

Kinnes, I. (2017). Contested governance: Police and gang interactions. Doctoral thesis, University of Cape Town, South Africa (Accessed 21 January 2025).

Kinnes, I. (2017). Contested governance: Police and gang interactions. Doctoral thesis, University of Cape Town, South Africa. http://hdI.handle.net/11427/252344 (Accessed 4 February 2025).

Korde, Ž., Šuriņa, S. and Mārtinsone, K., 2023. Research trends in Drama Therapy: a bibliometric analysis based on Scopus. *Frontiers in Psychology*, *14*, p.1327656.

Lawler, S. 2002. "Narrative in Social Research." In Qualitative Research in Action, edited by Lewis, D., 2014. *Non-governmental organizations, management, and development*. Routledge.

Longhurst, R., 2003. Semi-structured interviews and focus groups. *Key methods in geography*, *3*(2), pp.143-156.

MacMaster, L.L., 2010. *In search of a family: The challenge of gangsterism to faith communities on the Cape Flats* (Doctoral dissertation, Stellenbosch: University of Stellenbosch) (Accessed 21 January 2025).

Makanya, S., 2014. The missing links: A South African perspective on the theories of health in Drama Therapy. *The Arts in Psychotherapy*, *41*(3), pp.302-306.

Maphumulo, W.T. and Bhengu, B.R., 2019. Challenges of quality improvement in the healthcare of South Africa post-apartheid: A critical review. *Curationis*, *42*(1), pp.1-9.

Mayson, J., 2020. *The Shape of Drama Therapy in South Africa: Trends in Research and Practice* (Master's thesis, University of the Witwatersrand, Johannesburg (South Africa)).

McKaiser, E. (2015) 'Don't tell me who I am, black man', *Mail & Guardian*, Available at: https://mg.co.za/article/2015-12-03-dont-tell-me-who-i-am-black-man/ (Accessed 7 February 2025).

Mhlanga, D. and Garidzirai, R., 2020. The influence of racial differences in the demand for healthcare in South Africa: A case of public healthcare. *International journal of environmental research and public health*, *17*(14), p.5043.

Mlangeni, P., 2019. *A Feminist Paradigm for Drama Therapy in South Africa* (Master's thesis, University of the Witwatersrand, Johannesburg (South Africa) (Accessed 5 February 2025).

Morar, T., Breedt, J.E., Mdaka, N., Maaroganye, K., and Robertson, L., 2024. Is mental health in South Africa moving forward?. *BJPsych International*, *21*(1), pp.1-3.

Morey, Y. and Wilbraham, L., 2003. Rep/hairing the natural: Black hair and identity in post-apartheid South Africa. *APPEARANCE*, p.12.

National Department of Health. National Mental Health Policy Framework and Strategic Plan 2023–2030. https://www.spotlightnsp.co.za/wp-content/uplo ads/2023/04/NMHP-FINAL-APPROVED-ON-30.04.2023.pdf; 2023. (Accessed 21 January 2025).

News24 (2023) *Three arrested for murder of 6-year-old boy from Hanover Park*, 19 October. Available at: https://www.news24.com/three-arrested-for-murder-of-6-year-old-boy-from-hanover-park-in-cape-town-20231019 (Accessed 7 February 2025).

Nguse S., Wassenaar D (2021). Mental health and COVID-19 in South Africa.

Oamen, O.D., 2011. African storytelling and development. *Journal of African Literature*, *2*.

Orelowitz, Y.R., 2015. *In search of the' good enough mother': a case study of Drama Therapy with a group of unemployed mothers in South Africa* (Doctoral dissertation). (Accessed 21 January 2025).

Orelowitz, Y.R., 2015. *In search of the' good enough mother': a case study of Drama Therapy with a group of unemployed mothers in South Africa* (Doctoral dissertation) (Accessed 21 January 2025).

Patel, V., 2014. Rethinking mental health care: bridging the credibility gap. *Intervention Journal of Mental Health and Psychosocial Support in Conflict Affected Areas*, *12*(4), pp.15-20.

Patton, M.Q., 2002. *Qualitative research & evaluation methods*. Sage(Accessed 7 February 2025).

Payne, M. (2006). Narrative therapy (2nd ed.). London, England: Sage (Accessed 7 January 2025).

Pinnock, Don. 2016. Gang Town. Cape Town: Tafelberg.

Pirtle, W.N.L., 2023. 'Able to identify with anything': racial identity choices among 'Coloureds' as shaped by the South African racial state. *Identities*, *30*(3), pp.392-410.

Qhobela, L.P., 2015. *Dramatherapy and the South African context: an auto-ethnographic/self-reflexive investigation on how the perception of race impacts on the professional role of the developing (newly becoming) dramatherapist* (Doctoral dissertation). (Accessed 21 January 2025).

Rabiee, F., 2004. Focus-group interview and data analysis. *Proceedings of the nutrition society*, *63*(4), pp.655-660.

Ramlall, S. (2012). The Mental Health Care Act No 17 – South Africa. Trials and triumphs: 2002-2012. *African Journal of Psychiatry*, *15*(6), 407–410. https://doi.org/10.4314/ajpsy.v15i6.49 (Accessed 7 February 2025).

Oppelt, R., 2024. As die Cape Flats Kon Praat: Locality and the Literature of Precarious Living. *English Academy Review*, *41*(2), pp.86-102.

Rifkin, J., 2001. *The age of access: The new culture of hypercapitalism*. Penguin.

Robertson, L.J., Moosa, M.Y.H. and Jeenah, F.Y., 2021. Strengthening of district mental health services in Gauteng Province, South Africa. *South African Medical Journal*, *111*(6), pp.538-543.

Roman, S., 2019. *What Kaaps brings to the table: A sociolinguistic analysis of the intersection between language, food and identity in Vannie Kaap memes* (Doctoral dissertation, Stellenbosch: Stellenbosch University). (Accessed 7 February 2025).

Saldana, J. 2009. The coding manual for qualitative researchers. London: Sage Publications Ltd.

Salmons, J. (2014). Qualitative Online Interviews: Strategies, Design, and Skills. SAGE Publications. (Accessed 7 February 2025).

Sapien Labs. 2024. "Mental State of the World in 2023." Annual Report. https://sapienlabs.org/wp-content/uploads/2024/03/4th-Annual-Mental-State-of-the-World-Report.pdf (Accessed 7 February 2025).

Schmidt, Christiane. 2004. "The analysis of semi-structured interviews." *A companion to qualitative research* 253, no. 41. p258.

Seleme, B., 2017. Using Umgidi Wokulungisa (dramatic Stamping Ritual) Within Drama Therapy to Provide an Accessible Therapeutic Space for Cultural Beings with an African Worldview (Doctoral dissertation, University of the Witwatersrand, Faculty of Humanities, Wits School of Arts). (Accessed 7 February 2025).

Sharma, J.K., 2016. Oral Storytelling and Its Techniques. *International Journal of English Language, Literature and Humanities*, *4*, pp.269-281.

Sharma, M. and Majumdar, P.K., 2009. Occupational lifestyle diseases: An emerging issue. *Indian Journal of Occupational and Environmental Medicine*, *13*(3), pp.109-112.

Shisana, O., Stein, D.J., Zungu, N.P. & Wolvaardt, G. (2024) 'The rationale for South Africa to prioritise mental health care as a critical aspect of overall health care', *Comprehensive Psychiatry*, 130.

Sibony, Daniel (2010) Le sens du rire et de l'humour. Paris: Odile Jacob

Slade, P., 1995. *Child play: Its importance for human development*. Jessica Kingsley Publishers.

Smiley, S., 2015. Field recording or field observation?: Audio meets method in qualitative research. *The qualitative report*, *20*(11), p.1812.

Solomons, L. (2022) '"What freedom?" Gangs, poverty and death – life is a "nightmare" for many Cape Flats residents, *News24*. Available at: https://www.news24.com/southafrica/news/what-freedom-gangs-poverty-and-death-life-is-a-nightmare-for-many-cape-flats-residents-20220427 (Accessed 7 February 2025).

Solomons, L. & Evans, J. (2022) '"Mommy Mommy!": Woman hides under her bed as gunshots ring out in Manenberg gang war', *News24*. Available at: https://www.news24.com/southafrica/news/mommy-mommy-woman-hides-under-her-bed-as-gunshots-ring-out-in-manenberg-gang-war-20220317 (Accessed 7 February 2025).

Sorsdahl, K., Petersen, I., Myers, B., Zingela, Z., Lund, C. and Van Der Westhuizen, C., 2023. A reflection of the current status of the mental healthcare system in South Africa. *SSM-Mental Health*, *4*, p.100247.

South Africa. (2002) *Mental Health Care Act 17 of 2002*. Pretoria: Government Printer.

Spradley, JP. The ethnographic interview. Holt, Rinehart & Winston; New York: 1979.

Standing, A. (2006). *Organised Crime: A Study from the Cape Flats*. Pretoria: Institute for Security Studies.

Statistics South Africa (2019) *Sustainable Development Goals: Country Report 2019*. Pretoria: Statistics South Africa. Available at: https://www.statssa.gov.za/MDG/SDGs_Country_Report_2019_South_Africa.pdf (Accessed 7 February 2025).

Stats, S.A., 2022. Statistics South Africa. *Census 2022*

Stoffberg, M. 2023. How can Cape Flats youth overcome Environmental circumstances by using their Personal potential? Faculty of Commerce Graduate School of Business (GSB). http://hdl.handle.net/11427/38181 (Accessed 4 February 2025).

Taylor, E., 1998. A primer on critical race theory: Who are the critical race theorists and what are they saying?. *The Journal of blacks in Higher Education*, (19), p.122.

Tewolde, A.I., 2024. Experiencing Negative Racial Stereotyping: The Case of Coloured People in Johannesburg, South Africa. *Social Sciences*, *13*(6), p.277.

Tiwari, M. and Tiwari, M., 2012. Voice-How humans communicate?. *Journal of natural science, biology, and medicine*, *3*(1), p.3.

Trotter, Henry. 2019. Cape Town: A Place Between. South Africa: Catalyst Press

Valley, D. 2010. Afrikaaps. [Culture Unplugged.] https://www.cultureunplugged.com/document Accessed? (Accessed 2 February 2025).

Van der Westhuizen, M. and Gawulayo, S., 2021. Youths in gangs on the Cape Flats: if not in gangs, then what?. *Social Work/Maatskaplike Werk*, *57*(1), pp.118-132.

Van Heerden, M., 2016. *Afrikaaps: A celebratory protest against the racialised hegemony of'pure'Afrikaans* (Doctoral dissertation, Stellenbosch: Stellenbosch University). (Accessed 3 February 2025).

Vilakazi, N., 2021. *Implications for Drama Therapy in Working Single-Mother Households in the South African Context* (Master's thesis, University of the Witwatersrand, Johannesburg (South Africa). (Accessed 7 February 2025).

Watt, M.H., Meade, C.S., Kimani, S., MacFarlane, J.C., Choi, K.W., Skinner, D., Pieterse, D., Kalichman, S.C. and Sikkema, K.J., 2014. The impact of methamphetamine ("tik") on a peri-urban community in Cape Town, South Africa. *International Journal of Drug Policy*, *25*(2), pp.219-225.

Watt, M.H., Myers, B., Towe, S.L. and Meade, C.S., 2015. The mental health experiences and needs of methamphetamine users in Cape Town: A mixed-methods study. *South African Medical Journal*, *105*(8), pp.685-688.

White, M., and Epston, D. (1990). Narrative means to therapeutic ends. New York, NY:

World Health Organization, 2022. *World mental health report: Transforming mental health for all*. World Health Organization.

Young, M., 2016. Private vs. public healthcare in South Africa.

Appendix A: Ethics Certificate

UNIVERSITY OF THE WITWATERSRAND, JOHANNESBURG

SCHOOL OF ARTS ETHICS COMMITTEE
CONSTITUTED UNDER THE UNIVERSITY HUMAN RESEARCH ETHICS COMMITTEE (NON-MEDICAL)

CLEARANCE CERTIFICATE **PROTOCOL NUMBER: WSOA20241113-15**

PROJECT TITLE A Narrative Approach: Perceptions of Mental Health Services and The Role of Creative Arts Therapies in South Africa's Coloured Communities.

INVESTIGATOR	Ms. Abigail George 2358834
SCHOOL/DEPARTMENT OF INVESTIGATOR	WSOA – MA Drama Therapy
DATE CONSIDERED	28 November 2024
DECISION OF THE COMMITTEE	Approved unconditionally
RISK LEVEL	LOW RISK
EXPIRY DATE	Date of submission of the project Research Report

ISSUE DATE OF CERTIFICATE 28 November 2024 **CHAIRPERSON** S. Bhebhe
(Dr Sibongile Bhebhe)
(Prof Brett Pyper)

cc: Supervisor: Linda Mdena(Thibedi)

DECLARATION OF INVESTIGATOR

To be completed in duplicate and **ONE COPY** returned to the Chairperson of the School/Department ethics committee.

I fully understand the conditions under which I am are authorized to carry out the abovementioned research and I guarantee to ensure compliance with these conditions. Should any departure to be contemplated from the research procedure as approved I/we undertake to resubmit the protocol to the Committee.

Signature **Date** 5 / 12 / 2024

PLEASE QUOTE THE PROTOCOL NUMBER ON ALL ENQUIRIES